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American Journal of Surgery and Gynecology.

VOLUME XIII. ST. LOUIS, MO., NOVEMBER, 1899. NUMBER 5.

EXTENSIVE OPERATION FOR CANCER OF THE FACE.

BY J. F. BINNIE, A. M., M. B., C. M., KANSAS CITY, MO.

Professor of Surgical Pathology and Clinical Surgery in the Kansas City Medical College.

Works on operative surgery, while excellent as guides to the performance of typical operations, generally fail to aid one who is compelled to attempt the removal of extensive disease affecting several adjacent structures. The above fact and the interest attaching to the very extensive removal of cancer, prompt the writer to publish the following report:

Mr. R., aged 69 years, suffered for many years from epithelioma of the skin below the mouth. The disease was always of slow growth. It was frequently operated upon by various surgeons (both eastern and western), but always promptly recurred. When seen by the writer the tumor was the size of a hen's egg, or larger; was situated on the chin and perforated by an ulcerous fistula from which saliva constantly flowed. It involved the whole thickness of the chin, of the corresponding portion of the lower jaw and affected rather more than one-half of the floor of the mouth. The lower lip near the right angle of the mouth

FIG. 1.

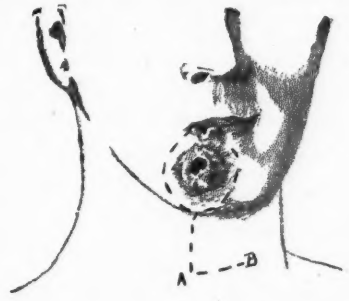
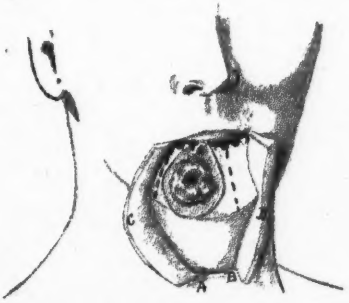


FIG. 2.



was pulled downwards, but not ulcerated. Near the tumor the skin was, in many places, replaced by scar tissue, the result of former operations. Only one lymphatic gland was found enlarged. It was situated below the right ear and lay in a mass of scar tissue. The patient and his physician noted recent greatly increast rapidity of growth. While recognizing the fact that operation often accelerates the growth of long-standing epitheliomata, yet in his case the recent rapidity of growth, the distress it was occasioning and the apparently localized condition of the tumor seemed to the author ample reason for operation. The general health of the patient was fair.

OPERATION—At the Sisters' Hospital, March 22, 1899, operation was performed; chloroform by Dr. Miller; assistants, Drs. Crist and Hibbard. Circumcision of growth (Fig. 1): The oral mucous membrane was not divided until all bleeding had been arrested; this avoided annoyance from blood getting into the mouth and some of the dangers of pneumonia from aspiration of blood into the lungs; the incision was extended under the chin and down on the neck to the point A (Fig. 1). From A a cut was made to B. The flaps AC B D were reflected (Fig. 2), exposing some of the soft parts of the neck, the floor of the mouth and a sufficiency of the lower jaw with the tumor attacht to it. The lower jaw was divided on either side of the growth. The tumor, the affected segment of jaw and the most of the floor of the mouth were removed in one piece. The free exposure of this field of operation and of the upper part of the neck by the reflection of flaps AC and BD permitted the operator to get, apparently, well beyond the disease and to examine closely any neighboring lymph glands. The lymph gland noted before operation was removed. The tongue was not involved. The remnants of the mucous membrane of the floor of the mouth were united by sutures. Flaps AC and BD were brought together with silkworm gut stitches. There was little bleeding and little shock.

INSTRUCTIONS FOR AFTER TREATMENT—Mouth to be washt with weak solution of permangenate of potash several times daily; drinking water to be taken ad libitum; all feeding to be by means of the esophageal tube; patient to sit up as soon as possible, this to avoid hypostatic congestion of lungs and dangers of pneumonia.

SUBSEQUENT COURSE—All the stitches held until removed. Highest temperature was 102 degrees Fr. There was little pus from the mouth. Two small abscesses, at points remote from the line of sutures, formed and were evacuated. The patient was sent home on April 8th.

In September (1899) Dr. Crist, the patient's physician, reported that there were no signs of recurrence and that the general health was thoroly satisfactory.

TREATMENT OF DISLOCATION OF THE SHOULDER JOINT; TUBERCULAR ABSCESS OF THE CHEEK; THE AFTER EFFECTS OF FROST BITE.*

BY WILLIAM C. DUGAN, M. D., LOUISVILLE, KY.

Professor of the Principles and Practice of Surgery and of Surgical Pathology in the Louisville Medical College.

Gentlemen.—Mr. S., aged 26 years, is the patient I spoke to you about a few days ago, who was supposed to have a dislocation of the shoulder joint. He was brought to see me Saturday, and the case so emphasizes the importance of the positive symptoms of dislocations in diagnoses I have had him come before you that they may be pointed out.

The patient, an athlete, spent several hours daily exercising in his gymnasium. The first symptom that he noticed was an inability to elevate his arm to the level of his shoulder. Without any history of an injury, he went along for about a year, going from bad to worse, and finally went before the Board of Medical Examiners for an opinion. This board is composed of gentlemen of high standing in the profession. They noticed this peculiar angular deformity with great prominence of the acromion process, and an inability to elevate the shoulder, which along with other symptoms we would expect to find in dislocation, and therefore made the diagnosis of irregular dislocation of the shoulder joint.

On careful examination I am unable to find a dislocation. He might have had one, with spontaneous reduction, which damaged the circumflex nerve, since his present trouble is that of neuritis of this nerve. I shall refer him to Dr. Pope, who may bring him before you again and lecture on the case more in detail.

When I stript the patient for examination, I found that the two arms were parallel, both hanging parallel to the median line. That in itself in such a subject should enable one to exclude dislocation. Then the "tape test" of Caldwell was tried, and the supposed dislocated shoulder measured one-half inch less than the other. The "tape test" is as follows: The patient sits or stands with the arms by his side; a tape line is drawn up into the axilla and over the acromion process, and if there is a dislocation the injured joint will be found from one and one-half to three inches greater in circumference than its fellow. There is not a member of this class, I am sure, who would not be willing to take the witness stand and testify that this man has no dislocation, after seeing the result of the "tape test."

There are a few simple tests that will enable you to say positively whether or not a patient has dislocation of the shoulder-joint and it is well to remember them. One of the most prominent and reliable tests I have already given. Another positive test is the following: Have the patient sit, stand or lie, with his arms by his side, then apply a straight edge to the outside of the arm, and if this can touch the acromion process while in contact with the external condyle, it shows that the head of the bone is out of the cavity. You observe as we apply this test, "Hamilton's straight-

*Clinical Lecture delivered at the Louisville Medical College. Reported for this Journal by C. C. Mapes.

edge test," as it is called, there is at least an inch between it and the acromion process. The third positive "test" is known as Duge's, and is applied as follows: Have the patient stand erect, as you observe; place the hand of the injured arm on the opposite shoulder; then with patient still standing erect endeavor to bring the lower end of the humerus to the side of the chest; and if it can be made to touch the chest there is no dislocation, for if there be a dislocation, the head must rest against the chest wall, and being a tangent to the chest circle at that point, and as the humerus is practically straight, and since a straight line cannot be tangent to two parts of a circle (chest) at the same time, the lower end cannot be made to touch the chest.

If you will remember these three tests, in fact, any one of them, you will always be in a position to be positive in your diagnosis of shoulder joint dislocations. There are many other symptoms to which I might call your attention, but as we have only a limited time in which to consider the methods of reduction of shoulder dislocations, I shall pass on—leaving the general symptoms for some future lecture.

There is one matter I have failed to emphasize, that is the stripping of the patient, so that both shoulders are exposed. Patients appreciate this, and rarely make any objections; but, in examining young ladies you should be most careful to not too fully expose their charms. Should a patient refuse to be examined, then say to her that it is unsafe to attempt to make a diagnosis of an injury of the shoulder without being able to compare the two, and rather than risk your reputation, have the patient to send for another surgeon. You may meet with such cases.

Having now considered the positive symptoms of dislocation of the shoulder joint, I beg to call your attention to the methods of reduction. The question of reducing a shoulder dislocation presents a great many features of interest. It is something that most of you will probably have to perform many times during your career as physicians and surgeons, and you should be familiar with some of the best known methods and understand their individual merits. When a patient applies to you with a dislocation of the shoulder joint, especially if it be in the acute stage, it is a case that you cannot very well send away for someone else to relieve; it demands immediate attention, and you must, therefore, be conversant with the different methods of reduction so that the one best suited to the individual case may be carried out. The operation (rather the manipulation) for reduction of a shoulder dislocation has been known since the days of Hippocrates. The country practitioner and the city doctor alike, and sometimes the farmer, are called upon to reduce such a dislocation.

The first method I shall briefly outline is an old procedure, and is known as the Sir Astley Cooper method: Have your patient lying on a couch, bed, or on the floor with a blanket or piece of carpet under him; the surgeon sitting down by his side. If you happen to see the case a few hours after the accident, there will be found little difficulty in reducing the dislocation, because the parts are so benumbed from pressure of the bone. Seated by the side of the patient (the injured side), with the shoe removed, slip your heel well up in the axilla so that the foot is against the axillary border of the scapula; then grasp the patient's hand firmly and abduct his arm and draw gently in line of the deformity, as I now demonstrate to you; draw until you feel the muscles relax and the head of the bone is felt to slip over the bony obstruction; then abduct the arm across the foot, using the foot as a fulcrum, all this time keeping up traction, and you will hear the bone slip back into its cavity. Remember in the first place to have your foot well up in the axilla, second make traction in line of the deformity until you feel the muscles relax and the head of the bone slip over the bony obstruction, then, third, having felt that, you draw the arm across the foot at the same time keeping up extension. This, as stated, is known as the Sir Astley Cooper method for reduction of a shoulder joint dislocation.

I will show you another procedure, which is also known as the Cooper method: Have your patient sit on a stool, while you stand behind him with your foot on the stool beside him, grasping the arm with one hand, lift it up and place your knee in the axilla. Now draw down on the arm, thus making extension, while you lift up on the shoulder with the knee in the axilla, making counter-extension.

This is a very good method, and you will find find that most cases of recent dislocations, can be reduced by this plan. The same principle, extension and counter-extension, is involved in both methods outlined with manipulation.

Another method is most applicable to cases of chronic dislocation: Have your patient lie flat upon a high table; abduct the injured arm and stand with your body as close up in the axilla as possible with your back to the patient. If the right arm is injured, bring it in front of you and reach your right hand around your body and grasp the right hand of the patient, then with your body between the patient's arm and body, holding firmly to his hand, you rotate yourself as I now show you. You have no idea the amount of force you can exercise in this way. As you turn yourself around in this way, you can feel the muscles relax, the bone is felt to slip over the bony obstruction, then with the free hand (or have your assistant do it), you can manipulate the head of the bone and cause it to slip into its proper position. There is some danger in this method, because so much force can be exercised that without care you are liable to do damage. It should be employed with the utmost care, and in selected cases only.

Another method is where you abduct the patient's arm at right angles, put your foot against the acromion process, grasp the hand firmly and draw on the arm abducted as indicated, until you feel the bone slip over the bony obstruction, then an assistant by proper manipulation of the shoulder may be able to slip the head of the bone into its cavity. The chances are that where the dislocation has existed for a long time, and in old people with diseased blood vessels especially, the irritation produced by the head of the bone will be considerable, and as a result of this, plastic material is thrown out between the ligament and the vessels and nerves, which are close to it, so when you abduct the arm and extend it in that position, you may cause rupture of some of these; especially is this liable to occur in elderly subjects with diseased blood vessels. Therefore, I beg of you to remember that you are not to use this method unless you have resorted to everything else, then only after telling your patient the dangers to which he will be subjected.

The next procedure is what is known as the Kocher method of reduction, and is superior to all other methods, since you can reduce every dislocation by this procedure that can be reduced at all, and the weakest member of this class can reduce them just as well as the largest, strongest man, for it calls into play skill and not physical strength and endurance alone. You take hold of the arm flexing it first, grasp the hand as I show you, flex the forearm and lift it up, then taking hold of the lower end of the humerus as you see here, then with this grasp, you have a double lever, and you lift up the arm and rotate it outward. The rule is first to flex the forearm, then rotate it outward, then lift it up to level of the shoulder, lastly passing the arm over toward the chest, rotating it inward, and at the same time the head of the bone is being manipulated and persuaded back into the cavity by your assistant. There is little chance of your making a failure, and if you cannot reduce a shoulder dislocation by the Kocher method, you cannot do so by any other method; at any rate, this has been my experience. In fact, I have been able to reduce old dislocations, which had withstood the other methods, and as to force, if you use the double lever action, you could easily fracture the bone or rupture the muscles.

I have briefly gone over the different methods of reduction by manipulative measures, and you may ask the question, supposing you have tried all these and failed to accomplish reduction, what are you to do? If you have exercised due care, and all manipulations have failed, there is only one of two things to be done, to-wit: To cut down upon the dislocated bone and attempt its reduction; failing in this, and there is complete loss of function, either from pressure on nerve or vessel or locking of the bones, you should excise the head of the bone.

As a rule, but little trouble is experienced in maintaining a reduction, but in old subjects with atrophy, or any age with atrophy from pressure, you will observe sagging of the shoulder from half an inch to an inch, so that you can feel the glenoid cavity under the acromion process, and may cause you to suspect that you have failed in the reduction, or that there has been extensive laceration of the ligaments. When you understand that the head of the bone is kept in its position by the supra and infra-spinatus muscles, and not by the capsular ligament, this is not to be wondered at. These muscles, with the teres minor, are inserted into the uppper part of the capsular ligament, and by constant traction, hold the bone in place.

TUBERCULAR ABSCESS.

The next patient, a male, aged 24 years, comes to us for treatment of a tubercular abscess or sinus leading from the lower jaw to the cheek. This is something that you should all understand, as such cases occur not infrequently. Examining the patient's mouth we can plainly see he has a dead tooth, which is evidently at the bottom of this trouble. All of you should know how to extract teeth. I met a physician recently who has been in practice for years in an adjoining State, who said that dentists in that part of the country were in the habit of referring patients to him to have teeth extracted; physicians are sometimes very dextrous in extracting. This man had an abscess around the root of this dead tooth some time since. As I have told you before, while lecturing upon abscesses, an acute abscess will generally point directly thru to the surface, whereas a chronic abscess will go in the di-

rection of least resistance. Now the abscess in this case, instead of working its way up along the edge of the tooth, discharged thru the alveolar process. If we were to take out this man's jaw bone we would find an opening leading directly thru the alveolar process into the cavity of the tooth. If we take out the tooth we will find that the opening communicates with the abscess.

As to the manner of dealing with these dead teeth: If it could be cleansed thoroly, and the cavity filled with volatilized iodoform, as is practist by Dr. Blair of this city, the tooth might be saved and be of service for years. If the tooth is too far gone, then you will simply extract it, treating the cavity by appropriate measures afterwards. How shall we deal with this abscess outside? If the patient were a young lady, we would treat it in one way, but as it occurs in a man, we will treat it by another plan. A small scar on a man's face amounts to very little, but in the case of a young lady, for cosmetic reasons, we should try to prevent scarring. To remove one of the deprest scars resulting from the so-called abscess of the tooth, you will make an elliptical incision, including all of the depression, separating and removing all the tissue, and put in buried sutures. You will find that the scar left after such an operation will be almost nothing, simply a white line. Remember in men it amounts to little or nothing, since they can let the beard grow to conceal the defect, or if they do not wish to do this, simply let it alone.

Now, this man's tooth is so badly diseased that it will be impossible to preserve it. I find down in the lower part of the buccal cavity there is another fistulous opening; so it is discharging in two ways, one thru the mouth, the other below on the outside. The first thing, after extracting the tooth, is to treat this sinus, or fistula. Sometimes we speak of these two conditions, using the terms synonymously. I believe this is entirely wrong. A fistula is a tubular abscess penetrating thru tissue connecting two surfaces. A sinus is one that connects the surface with a deeper part. In this case, I take it, the external opening communicates directly with the tooth, so I speak of it as a sinus, whereas if it communicated with the skin outside and the buccal cavity within, I would speak of it as a fistula. The first indication is removal of the cause of the sinus; the cause of the trouble is the dead tooth. Just as long as this dead tooth remains, the man will have a discharge. It will do no good to inject peroxide of hydrogen or a weak solution of carbolic acid or a solution of the bichloride of mercury, etc., just as long as the tooth is allowed to remain, the discharge will continue. Therefore, remove the tooth, or in some instances cleanse it thoroly, removing all dead tissue. But since this tooth is so badly diseased that it cannot be preserved, we will extract it.

Those of you who are going to buy forceps, I would advise to procure good instruments, because it is bad enough for the patient to have a tooth extracted, and to have the instrument slip off once or twice is torture. I show you what is called the cowhorn instrument for extracting the lower teeth. For the eye teeth you need another pair of forceps, and for the teeth that have three roots you may use forceps with three prongs. To obtund pain you can use cocaine, or what is supposed to be better, because safer, eucaine; the latter is said to be without danger.

In extracting lower teeth, be careful never to let your instrument strike the upper jaw. I can understand how suits for malpractice might be instituted where upper teeth were broken by forceps striking them.

By examining the tooth which we have just extracted you will observe that the roots are very much disorganized, caries being markt. The after treatment is thru and thru irrigation with hot water. Instruct the patient to wash out the mouth often, and as a rule, such fistulae heal kindly. The deprest scar may be dealt with as indicated above.

BAD RESULT OF FROST-BITE.

This man, aged 41 years, occupation teamster, applies to us for treament because of a swelling of his right foot. The history is that his foot was frosted two years ago. You will see his foot is now swollen, and the skin drawn tightly over the dorsum of the foot, the tendons and sheathes are matted together so that it is impossible to locate them. Every time his foot gets cold it gives him intense pain. Those of you who have always lived in the Southern States do not realize the gravity of a condition of this kind; while those who live in the North, Northwest or Northeast can appreciate the pain that follows upon frost-bitten hands or feet. It is a peculiar burning pain, and the parts become very much congested.

I want you to examine the dorsum of this man's foot, and you will find no evidence of the tendons, they are matted together. You will find that the sheathes and tendons appear as one, and if you would open these parts,you would find everything run together, as it were, there is no synovia at all. This condition is the result of neuritis, caused by the frost bite. A foot badly frosted is so lowered in vitality that it is a long time in undergoing resolution. This man's foot is useless, and would better be amputated, as he is liable to develop gangrene at any time after slight exposure to cold. He should not expose himself to cold, damp weather, but you see, he is a poor man, and his occupation requires that he be out in all kinds of weather.

I present this case for two reasons—first, to show you the result of bad frost bites; second, to emphasize what I said to you about the importance of prolonged treatment and securing resolution before the patient is exposed to cold and damp weather; third, to prevent neuritis, which is so apt to develop in these cases.

(This patient has since gone into the hospital with gangrene of the foot, and I amputated thru the lower third of the leg.—W. C. D.)

SOME PRACTICAL POINTS IN THE TREATMENT OF DISEASES OF WOMEN.

BY EMORY LANPHEAR, M. D., PH. D., LL. D., ST. LOUIS, MO.
Formerly Professor of Surgery in the Kansas City Medical College and Professor of Principles and Practice of Surgery in the St. Louis College of Physicians and Surgeons.

"Osteopathy" cures; "Christian Science" cures; even "Weltmerism" (the latest fad) cures—certain cases. There is no use attempting to deny it; it is a fact. Under the influence of each, pains and aches grow less, health and strength return; patients become happy and ascribe their good feeling to the special form of "treatment" they have received.

The underlying factor of each "system" of treatment is one too long ignored by the regular profession—a principle upon which is based the extraordinary cures from the numerous "shrines," "relics," etc., and by "faith healers," "magnetizers," et id omne genus. It is one which every gynecologist should know all about, and apply in his work.

It is auto-suggestion! This is the great principle; and should be the basis of practically all treatment in non-operative gynecology.

Of equal importance is the necessity for remembering four great causes of chronic invalidism. It may be truthfully said that of the total number of women who throng the offices of gynecologists not more than one-third suffer from ailments which need either surgical or "local" treatment. The vast majority of female aches, pains and complaints depend—not upon pelvic lesions—not upon "neurasthenia," nor "hysteria;" but upon—

1. Chronic constipation.
2. Indigestion.
3. Anemia.
4. Sexual hunger.

Correction of one or more of these troubles will cure those patients who, year after year, form the clientele of doctor after doctor, flitting from one office to another; always more than half sick, yet never quite ill enough to submit to an operation, even if one is indicated (but rarely the case); always seeking the relief which never comes; unhappy, discontented; finally becoming melancholic patent-medicine fiends, or worse.

The object of this paper is to direct attention to the manner in which the element of auto-suggestion may be made to cure these patients; with hints as to proper medication.

First. The less "local treatment" used the better for the patient. Too many women are being "swabbed" and "tamponed;" too few treated rationally. The less the attention of the patient is directed to the pelvis the better for the woman—paricularly the one suffering from sexual hunger.

Second. The average woman takes from a pint to a quart of fluid every day, instead of the three quarts (or thereabouts), which every grown person ought to drink. If the patient be sent to a watering place, like Eureka Springs, she improves—not from change of scene, not from freedom from worry, not from the medicinal effect of the waters, but from (a) the increast amount of water she drinks, (b) from the auto-suggestion that from every drink of water she takes she is going to improve, (c) from the outdoor air she breathes. If she would take the same quantity of water at home, with the same sort of suggestion that it will relieve, and take more out-of-door exercise, the same results would be attained; and the doctor, instead of the health-resort be given the credit. How may this be accomplisht?

Third. The average woman likes to take medicine. The doctor must profit by this. If she is told to take a glass of water every hour (at home), she will rebel, or fail to take it, even if she agrees to—she thinks it of no value; and with the common run of women, it is useless to explain why she ought to take more fluids; to increase the gastric juice, to liquify the intestinal contents, to improve the blood, to flush the kidneys, etc.—all points known to every physician, but too much ignored in therapeutics. So she must be given some excuse for using so much water! She is, there-

fore, given medicine, of which she is to take a certain dose in a gobletful of water every hour! A common prescription of mine (which overcomes the anemia so often accompanying the constipation, indigestion and the sexual neurasthenia), is eight drops of Gude's Pepto-mangan, with one drop of liquor arsenicalis, to be taken in a glass of water every hour, from 8 a. m. to 8 p. m.

Fourth. With the medicine must be associated the application of the principle of auto-suggestion. If the medicine is simply given with directions to "take it as directed, and it will help you," some good will result, but not a cure. To get the full therapeutic value, we must bring to our aid that power which cures in the hands of "Christian Scientists," (ignoring pain, or declaring again and again that it does not exist or can't exist) in the work of the "high dilution" homeopaths, and other like "systems:" auto-suggestion of a cure of certain things.

(A) As to chronic constipation. The first point for securing success is to agree upon some proper hour—most convenient to the patient—for the bowels to move. Let us say 9 o'clock is agreed upon. The patient is then told in the most impressive manner possible: "The medicine is to make your bowels move at 9 o'clock! Every time you take a dose of medicine you must think—think—think:"This is to make my bowels move at 9 o'clock;this is to make my bowels move at 9 o'clock; this is to make my bowels move at 9 o'clock, And it will! Every morning at 9 o'clock you must go to the closet and try to have a movement. It will not be long until you will have one at that hour, whether you try or not!" The patient may smile at this, or regard it as a huge joke; if so, so much the better—she will be the more apt to make the desired auto-suggestion than if she takes the matter semi-seriously; if she accept the advice seriously, the treatment is sure to win. With the increast amount of fluid peristalsis is certain to be accelerated; with the oft-repeated suggestion, the abdominal brain will soon learn to send the necessary rectal stimulus at the appointed hour. And a cure will be effected in a few weeks, even in the most obstinate case.

(B) As to indigestion. If in addition to the constipation, there is a decided want of nutrition, an indigestion, it may also be cured in the same way. The increast amount of fluid taken will promptly fill out the capillaries, will improve assimilation and change the character and quantity of gastric juice; so that digestion will soon be vastly benefited. But in addition to the favorable influence of the increase of fluids must once more be applied the principle of auto-suggestion. After the patient has become familiar with the song about bowel movement, another verse is to be added: "When you take your medicine every hour you are to think about the bowels; and besides, you are to think: 'This is to make me hungry, hungry, hungry all the time; it will improve my digestion, improve my digestion, improve my digestion—it WILL make me better and fatter and happier every day.'" And it DOES!

(C) As to the anemia. In all my experiments in the treatment of anemia, there is no remedy I have found equal to Gude's pepto-mangan, already mentioned. It is good without the suggestive treatment; it is better with. In every case of anemia (and nearly all gynecological patients are anemic), I now make a blood examination. If the number of red blood corpuscles are not materially diminisht, but the hemaglobin is scanty, I use the pepto-mangan alone; but if there is an extraordinarily low quantity of hemaglobin with markt diminution of the red blood cells, I combine with it the official liquor arsenicalis (liquor acidi aresenios), In many cases there will be no necessity for employing auto-suggestion—the drugs are simply to be taken in the usual dosage an hour or so after each meal. With most patients, however, the necessity of bringing suggestion to the aid of medicine is apparent very soon to the practist eye; and the woman is instructed to take the medicine, nine drops of medicine in a glassful of water every hour, and at the same time to think: "This is to make more blood; to make more blood, to make more blood; to make me stronger and better every day." The results are truly wonderful, as I have verified by numerous blood tests in a series of bad cases. The gain in body weight, the improvement in general health, the change in the character of the blood are almost phenomenal, and may be ascribed to (1) the increast amount of fluids taken, (2) the influence of the mind over the bodily functions, and (3) the excellent therapeutic remedies employed.

(D) As to sexual hunger. This is a most important and much neglected subject. Young women who masturbate (and their number is legion—almost as great as that of young men) and those whose passions have been aroused by the too-oft repeated caresses of sweethearts, suffer greatly from sexual hunger. Unless gratified by early marriage or illicit intercourse these girls develop most persistent leucorrhea, with backaches, headaches, etc., finally becoming hysterical, neurasthenic, anemic, often seriously ill—yet the closest examination fails to show any organic lesion anywhere. Here one cannot usually accuse the woman of self-abuse, and make the suggestion to stop it; but equally good results may be obtained by the correction of the anemia, constipation and indigestion, by the methods just mentioned, with the further advice to ABSTAIN FROM ALL POSSIBLE SEXUAL IRRITATION. The girl will understand. Later, as general improvement becomes markt, the suggestion may be made: "Keep your mind free from thoughts of your generative organs. Every time you take your medicine think: 'This is to cure me and keep me pure,'" or words to that effect. Such suggestions have the most marvelous effects in many instances.

With married women sexual neurasthenia depends upon (1) some abnormality of the genital make-up; (2) the practice of "withdrawal" to prevent conception; (3) too frequent self-induced abortions; (4) premature emissions on the part of the husband. Every married woman who consults the gynecologist should be carefully questioned as to her sexual relation—some irregularity of which will be found to underly a large proportion of "female weaknesses." Examination may show an adherent clitoris, giving rise to constant sexual desire without probability of perfect gratification; a clitoris placed abnormally high, so that during intercourse, the husband does not sufficiently irritate the woman's erectile organ—he gets the orgasm, she gets "left"—which finally leads to ill-health, irritability, etc., all of which might be corrected by advice to the husband to "ride high;" and so on. The average gynecologist will easily detect any such abnormality and adopt proper measures for its correction. Relief from the cause and attention to the general health of the individual on the lines already laid down, will promptly restore the patient to health. The practice of withdrawal—so hurtful to both parties, must be checkt; proper medication directed to the general health, with the right amount and kind of sexual intercourse, will cure the woman without any local measures in most instances. The production of abortions must be arrested; if lacerations have been produced, or inflammatory changes in the uterus, they must be corrected by operative procedures; and the general health of the patient attended to in the manner already indicated; with restoration of good health and proper sexual relations, the sexual hunger will be appeased and another household made happy. A large percentage of sexual starvation in the female depends upon imperfect intercourse through the fault of the male. As a result of (1) early, excessive masturbation; (2) venereal excesses, (3) long-continued withdrawal or (4) old gonorrhea, a condition of irritation or chronic inflammation of the deep urethra arises as a result of which the seminal vesicles empty themselves too prematurely—to the disappointment of the female. The results are: (a) If the woman recognize the fault she resorts to (1) masturbation to satisfy the craving for the production of the orgasm, (2) gratification of her amorous desires in the arms of a clandestine lover, (3) the divorce courts to free her from a man whom she feels can never satisfy her, or (4) the physician, who should at once recognize the necessity of curing the husband—usually an easy task by proper measures. (b) If the woman does not discover the source of her uneasiness, discontent and general discomfort, she finally (1) loses all interest in the sexual act, becoming "cold" and indulging in intercourse merely in a passive way for the gratification of the man she once loved, and may still greatly admire and respect, or (2) persists in her attempts to get that satisfaction which she feels in her inmost soul should be hers, until at last her health fails and she consults her physician. Here the wise gynecologist recognizes the futility of measures addrest solely to the pelvic organs of the female. He cures the man of his sexual weakness, teaches him how to have intercourse normally, and gives the woman the general line of treatment previously outlined.

Were these things more thoroly understood by both laymen and physicians in general, there would be far less unhappiness, far less infidelity, and much would have been accomplisht toward the suppression of "the social evil."

Fifth. In carrying out the suggestive measures in this line of treatment, the patient should return to the office as often as every third day, that the directions may be repeated over and over again. In oft repetition lies success. The more thoroly the patient can be impresst with the importance of auto-suggestion, the better the results.

Sixth. In making the suggestion, it is best to have the patient recline on the operating chair or table, close the eyes and relax the muscles, thus giving undivided attention to what the doctor is saying.

Seventh. It is well to agree upon a certain sum of money for a four or six weeks' course of treatment, and exact payment of half the fee in advance. The patient who has paid for treatment carries out instructions far more faithfully than one who can stop at any time, pay up and quit. By the time half the fee has been used up, the patient will be as anxious as the doctor to continue the improvement already so apparent to all.

Eighth: Conjoined with the increase in fluids, with the auto-suggestion, and the Gude's pepto-mangan with arsenic, as much out-door exercise as possible is to be ordered. With these four things, the most remarkable changes can be wrought—far more lasting, often far more startling, and always more creditable to the medical profession than any cures effected by any of the numerous cults so popular with the people at large.

Ninth. It is necessary in every case to make a thoro examination of the patient; first, to ascertain the existence of any organic lesion which needs operative or other active treatment, second, to impress the mind of the patient with the earnestness of the doctor and his determination to get at the seat of the trouble and eradicate it.

Tenth. Anyone interested in the subject of suggestive therapeutics on rational lines will do well to write to Herbert A. Parkyn, M. D., Principal of the Chicago School of Psychology, to whom I must acknowledge my indebtedness for some of the most valuable points of my paper.

THE MOST SUCCESSFUL TREATMENT OF SPINA BIFIDA.*

BY W. O. HENRY, M. D., OMAHA, NEB.
Professor of Gynecology in the John A. Creighton Medical College, Gynecologist to St. Joseph's Hospital, Formerly Surgeon-in-Chief to the Presbyterian Hospital.

Spina bifida, the subject of my brief paper, is one of the most distressing conditions which the mother ever witnesses in her new-born child. She recognizes it at once not only as a deformity, but as a serious menace to the life and health of her offspring, as well as one which makes it extremely difficult to handle the child. By the term we simply mean a protrusion of a part or all of the contents of the spinal canal thru an abnormal opening in the vertebrae from lack of development.

As to the cause of it, nothing is known. It often occurs in connection with other malformations as hydrocephalus, cleft-palate, hare-lip, club-feet, or other similar defective development, but why any of these should exist has never been determined, nor any satisfactory theory advanced.

As to the location of the hernia, it may occur anywhere in the course of the canal, but is most common in the lumbar and sacral regions.

Three varieties are generally recognized: First—Meningocele, or the hernia of the membranes alone, filled with cerebro-spinal fluid. Second—Myelo-Meningocele or protrusion of the cord or large important nerves, together with the membranes filled with cerebro-spinal fluid. Third—Myelo-Cystocele, or Syringo-Myelocele, that in which not only is the whole thickness of the cord and its membranes in the protrusion, but the central canal of the cord is dilated into a pronounced cyst.

Bradford and Lovett in their "Orthopedic Surgery" give no account of this deformity; but in his article in Park's Surgery, Bradford says: "In the majority of instances, the tumor ruptures during infancy, the fluid is evacuated, and the patient dies with convulsions or from a septic spinal meningitis."

Sayre gives a short description of the trouble and says: "The treatment of this disease is very unsatisfactory." He does, however give the details of one case which he cured by simple ligation many years ago.

Wyeth says in his most recent work, "The prognosis is as a rule very unfavorable."

Da Casta says: "Spina Bifida usually causes death."

Tillmanns says: "Meningoceles alone are capable of successful surgical treatment."

Muscatello advises against operations for Myelo-Meningoceles.

According to Wernitz, of 90 children with spina bifida, not operated upon, the majority died within five weeks of birth and only twenty lived to be over five years old. Since the mortality is so high unless something is done to save life as well as to relieve the deformity, two lines of treatment are in vogue, at the present time, each having its special advocates.

THE INJECTION TREATMENT.

By the introduction of irritating fluids it is hoped to produce adhesive inflammation and obliterate the sac. Of the fluids thus used, it may be said that Morton's (iodine, 1 part; iodide of potash, 6 parts, and glycerine 50 parts) is undoubtedly the best.

There are several serious objections to this method of treatment: First—The great danger of meningitis; second, the danger of death on the table from the use of any of these fluids; third, not knowing positively the contents of the sac it would be a serious matter perhaps to produce an adhesive inflammation between the walls of the sac and the important nerves or possibly the spinal cord, leaving all outside of the natural bony canal in which they belong.

The London Clinical Society found that of 82 cases thus treated 37 died, 35 recovered, 4 were slightly improved and 5 were not benefited. Powers found of 15 cases treated with Morton's fluid 4 died; or, there was a mortality of 26.66 per cent. In the "Annual" for 1896 it was said in reference to the use of Morton's fluid: "A number of cases are known to have died on the table while being subjected to this operation, while others have succumbed to a rapidly developing hydrocephalus."

OPERATIVE TREATMENT.

The only other practical line of treatment is excision. Hildebrand has collected from literature 87 operated cases, with 73.5 per cent. of cures. Hanson has collected 150 cases operated upon with a mortality of 29 per cent. since the days of asepsis. Powers, of New York, gives a table of 31 excisions, and 7 deaths, or a mortality of 22 58-100 per cent. Robson reports 20 excisions, with only 4 deaths, in his own experience; so, at the present time it is not only more scientific and rational to open the sac of spina bifida, replace the contents in their natural spinal canal, cutting away the surplus and by careful suturing and compress retaining them there than it is to use the injection method; but the percentage of cures is also greater and the mortality is less.

As to the ages of the patients undergoing the operation for this deformity, they differ widely. Walther operated successfully upon a case only four hours old, while Ricord cured a young woman of severe nervous symptoms by operating upon her spina bifida when she was 25 years of age.

The foregoing facts ought to teach us several things:

First—Not all cases of spina bifida require either injections or other operative treatment. If the protrusion is small and the skin over it is not too thin, it may be crowded into its bony canal and held there by a firm compress. This, or just as much compression as it will bear, should be applied carefully when first discovered by the physician in charge. A gutta-percha, celluloid or pasteboard shield held in place with adhesive straps and bandage being perhaps the most efficient and simple means of accomplishing the desired result.

Second—The very large majority of cases demand some radical treatment, and the percentage of cures in skillful hands will not fall below 70 per cent. or 80 per cent.

Third—The operation of excision is both more scientific and successful than the injection method.

Fourth—When operation is needed no child is too young for a successful operation.

Fifth—When paralytic or other nervous symptoms arise from spina bifida, no matter how old the patient, benefit may accrue from a skillful operation.

Case—Henry C. was a nine-pound boy, healthy and well-formed in every respect except that he had a spina bifida in the lumbo-sacral region. He was brought to me when thirteen days old, with a protrusion as large as a good-sized orange which had been increasing in size since birth. The skin over it had become exceedingly thin, was beginning to ulcerate, and lookt as tho it might burst any moment. It was not pedunculated; indeed, it had a very wide base. Operation was advised, and the next day the babe, being just two weeks old and properly prepared, the head of the child being placed lower than the buttocks, according to the suggestion of Marcy, chloroform was given, a trocar was introduced, and the fluid drawn off, it being found to be in several distinct sacs. After evacuation was completed, an incision was made in the median line, where the several cavities and the spinal cord were exposed to view; the entire membranes were then carefully dissected, from the superimposed tissues down to the spinal canal, where the opening was large enough to admit the end of my thumb. I now tied the mouth of the sac with a chromicized catgut and then pusht it with its contents into the canal, putting all of the structures back where they belonged, and by firmly tying the opening in the membranes with a freehand catgut, I prevented the escape of much cerebro-spinal fluid. The fascia, muscles and skin were then firmly sewed over the spinal opening, in several layers with the same kind of gut, the surplus skin having first been cut away. Boric acid was dusted over the wound, gauze, cotton and a firm pasteboard compress were now securely fastened by means of adhesive plaster and bandage. There was very little loss of blood, almost no shock, and he stood the operation well, so that he was carried to his bed in good condition at about 10 a. m. During the day his temperature gradually went up until at 5 p. m. it was 104 and the pulse about 150. However, he nursed well, and appeared in all other respects to be doing first rate. The next morning his temperature was 104 2-5 and pulse 150. The fontanelles were distended and he began to show some nervous symptoms, as twitching of muscles and sudden starting in sleep. Ice was ordered to his head, but in a short time he had three convulsions, one quickly succeeding another. The head was elevated and ice continued.

*Read before the Missouri Valley Medical Society.

If convulsions continued it was the plan to puncture the anterior fontanelle and draw off some of the cerebro-spinal fluid, as it was believed that this was the cause of them. However, the temperature gradually declined, the tension became less from day to day and there were no more convulsions. There appeared some superficial suppuration in the wound, which gradually disappeared under daily cleansing, so that in about three weeks from the time of operation the child was taken home in good condition, having grown rapidly and being much larger and stronger than when it came under observation. Of course it will be necessary for this child to wear a suitable compress until nature has time to throw out the natural bony processes, which should cover and protect the cord and its membranes. With this precaution now there is no reason why he may not be as perfect in body and health as tho no such defect had ever existed.

A CASE OF ADENO-SARCOMA IN A NEGRESS.*

BY AUGUST SCHACHNER, M. D., LOUISVILLE, KENTUCKY.
Professor of Surgery in the Louisville Medical College.

This is a specimen which again illustrates the point I made at a meeting of this society some time ago. You will remember I stated that the idea prevailed in this city particularly that the Ethiopian race is practically immune from both carcinoma and sarcoma. Upon further investigation it has been proven that this is not only an error, but that the colored race is more liable to both carcinoma and sarcoma and these diseases are relatively much more fatal than in the whites.

The specimen before you proves to be an adeno-sarcoma removed from a woman (negress) twenty-eight years of age, with a history having a small enlargement in the lower part of the right breast for some time. This enlargement has remained quiescent until two or three months ago, when it began to take on active growth, until the breast when removed was at least four times as large as its fellow on the opposite side.

The specimen illustrates a good many features in the differential diagnosis between carcinoma and sarcoma. There were no lymphatic enlargements at the time of the operation, tho she said, however, that six weeks before the lymphatic glands in the axilla were enlarged for a short time, then subsided. The principal diagnostic features between carcinoma and sarcoma are illustrated here; the tumor is encapsulated, as you see, which is contrary to carcinoma, where there is a tendency to infiltration thruout the entire gland. There is absence of the changes so markt in carcinoma; there is no retraction of the nipple, and in addition to that the age of the woman points to sarcoma rather than to carcinoma, and there are some enlarged vessels coursing in the direction of the nipple. Notwithstanding the fact that the diagnosis pointed toward sarcoma rather than carcinoma, and altho sarcoma spreads only thru the blood vessels, still it is generally conceded it is the best plan to clean out the axilla and take out the neighboring glands in operating for sarcoma.

I operated in this case, removing all the neighboring glands and the axillary contents. The capsule of the tumor was intact, and to make sure that everything was gotten away I also removed the upper third of the pectoralis major muscle. You will observe the tumor distinctly encapsulated; there are not infiltrations; there are no masses of fat; the structure being somewhat fleshy, having the typical appearance of sarcomatous tissue.

The specimen is of interest as strong illustration of the differential diagnostic points between carcinoma and sarcoma, also is another evidence of the error which has been prevalent here that the negro race is practically immune to these malignant processes.

DISCUSSION.

Dr. Wm. Cheatham:—I have reported one case of sarcoma of the tonsil in a negro. I thought the trouble syphilitic, but askt Doctors Cartledge and Dugan to see it, and they diagnosticated sarcoma, which was later proved by microscopic examination.

Dr. J. W. Irwin:—This is a question that I have never heard discust before, more especially touching the infrequency of carcinoma and sarcoma in the negro race. I had thought there was no material difference so far as my observation went as to the frequency of occurrence of malignant disease in the white and black races. I had thought there was no race exempt from either carcinoma or sarcoma, and if my opinion had been askt without knowing positively I should have stated that was about the rule. With an experience extending over twenty-five years in practice, I have met with a great number of cases of sarcoma and carcinoma in the colored race, and I believe if there is any difference carcinoma occurs more frequently in the colored than in the white race. Within the last four months I have seen two cases of carcinoma of the breast in negro women, one aged thirty-four, the other twenty-eight; and within the last six weeks I have seen two cases of what I was forced to diagnosticate sarcoma of the liver in the negro race, one in a girl nineteen years of age, the other in a woman aged twenty-six. The nature of the growths, the ages of the patients, the rapidity of the growths, the enlarged abdominal veins, and all the symptoms being taken into account, I regarded these two cases as sarcoma of the liver and not carcinoma. All the cases of malignant disease in the colored race that I have seen within the last year have occurred in females, altho I have previously seen males so affected.

*Reported to the Louisville Clinical Society. Stenographically reported for this journal by C. C. Mapes.

DIAGNOSIS AND TREATMENT OF UTERINE FIBROMATA.*

BY MILO BUEL WARD, A. M., M. D., KANSAS CITY, MO.
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So far as concerns the diagnosis of uterine fibroids, there is very little that can be added to the general knowledge of the subject, because most of the symptoms indicating these conditions are already familiar to the profession. We occasionally, however, find these growths present in some form when there is an absence of the usual symptoms accompanying these conditions. The only positive knowledge of the existence of a tumor is the physical demonstration of the growth. The usual symptoms accompanying fibroma aid us materially in determining the character and location of the growth. For instance, a sub-mucous fibroid or polypus causes more bleeding than is usually present when the growth is of the interstitial variety, and the latter condition is more frequently accompanied by hemorrhage than is the sub-peritoneal class. So far as I know there is always a history of metrorrhagia as a symptom of polypus.

We are also taught that there is always more or less metrorrhagia in connection with the interstitial variety. Personal experience, however, has convinced me that we cannot always depend upon a history of unusual bleeding in making a diagnosis of interstitial fibroid. Two cases demonstrating this fact have recently come under my observation. One, an unmarried woman about twenty-four years of age, with an interstitial fibroid the size of a large cocoanut with a history of only scanty menstruation. The other patient was forty-seven years of age, and the tumor weighed fifteen pounds. In this case the menstruation was normal. So far as I recall these are the only cases which I have personally observed, but they are sufficient to permit of the statement that we cannot always depend upon a history of bleeding as a diagnostic symptom in uterine fibroids. Uterine hemorrhage is not particularly common in the sub-peritoneal variety.

The physical demonstration of growths of the uterus is comparatively easy as a general rule. Occasionally, however, we find it very difficult to differentiate a small fibroid of the interstitial variety from the uterus itself. Where there is any doubt regarding the diagnosis, it is well to thoroly empty the lower bowel, place the patient in complete anesthesia and make the examination both per vaginam and rectum. With the skill that comes from a large experience in this method most cases can be diagnosed.

Where the tumor is of the myomatous character—that is the soft variety—we will frequently find a large amount of fluid in the peritoneal cavity, which will tend to embarrass us and may lead to error in diagnosis.

In the management of any of the varieties of uterine fibroids, experience will prove to be an invaluable aid. Numerous complications are frequently concommitant with uterine growths, and the least of these must not be lost sight of in giving an opinion relative to the treatment of each case. It is not sufficient to be content with the fact that a tumor of the uterus is present, but, before we can intelligently recommend the course to pursue, it is essential that we become familiar with all the physical symptoms depending upon, as well as those which many have caused the growth, before we decide upon the plan of treatment.

As a rule, it is safe to say that uterine fibromata are surgical. However, it is wise to be very conservative in passing opinion that all tumors of this character should invariably be removed. It is not infrequent to find that this character of growth has developt in conjunction with other physical derangements of such character as to contra-indicate surgical procedure. The best results obtained from experience do not depend altogether upon the skill of the operative procedure, but as well upon the wisdom of the conclusions regarding the complications likely to result from the surgery performed. No surgeon is so wise as to always be competent to say with certainty just what complica-

*Read before the Kansas City District Medical Society.

tions may be found in any case, but the more varied his experience, accompanied as it should be with patient research, the more valuable to all concerned will be his conclusions.

It is the writer's wish in dealing with this subject to do so from a standpoint of personal observation, and to avoid the repetition which comes from quoting from text books and journal articles. Therefore, as my own opinion, I may repeat, most fibroids of considerable size should be removed, unless the patient presents conditions which contra-indicate operative interference.

It is very rare, indeed, that we observe serious obstacles to the performance of necessary surgical operations. Even patients who have slight, and perhaps it would not be too radical to say severe, heart lesions, may undergo surgical operations without any great danger from the anesthesia. Every surgeon will recall patients who have been informed that they could not take ether or chloroform, and have thereby been unduly frightened and led to postpone surgical relief unnecessarily.

So long as uterine tumors do not cause pressure symptoms nor reduce the patient's vitality in any way there need not be, as a rule, any urgent necessity for prompt surgical interference. In this connection, however, we must not lose sight of the fact that uterine tumors usually continue growing and must eventually be removed, and that the complications are less when the tumors are small, giving us far better results when we operate early in the history of the growth.

Time and experience have furnisht us the valuable lesson that operations for cutting off the blood supply of these growths are too uncertain in their results to be worthy of our recommendation. It is not my desire, however, to wholly condemn removal of the appendages, in properly selected cases, for the cure of uterine fibromata, but we have to admit that the results are uncertain. The patient should be informed regarding the probable result and thus place the responsibility where it belongs. So far as concerns ligating the uterine arteries, the subject may be dismist as having no special merit.

The question of age is, of course, to be considered. Women advanced in years and who do not seem to suffer from the growth may live their alloted time, and thus avoid the ordeal (even tho the danger be slight) of a surgical operation. Regarding the result of the menopause on uterine growths, we are all familiar with the fact that the time of complete cessation of menstruation will be more or less prolonged in cases of fibroid complications. If the tumor has grown rapidly prior to the period of menopause, it may or may not cease to grow after this epoch is establisht. It is, therefore, wise to be very guarded in giving opinion regarding the influence of menopause on uterine growths.

In view of the fact that most fibromata must or should be removed by celiotomy, we will do well to frequently resort to myomectomy instead of hysterectomy, in all suitable cases. It is a well establisht fact that many uterine tumors may be removed from the uterus and this organ permitted to remain. Nearly all sub-peritoneal fibroids, even tho they be quite formidable in size, may be removed independent of the extirpation of the uterus. Some operators are also removing by this method interstitial fibroids, but my experience will not justify me in recommending this operation for this class of tumors.

It does not seem necessary to even mention any medical or electrical treatment, as in any way curative of uterine fibromata. These conditions are either surgical, or nothing at all is to be done with them. This observation may at first appear very sweeping and dogmatic. However, the profession is practically of one opinion regarding this phase of the management of these growths. The mention of medicine in connection with this subject would be irrelevant, were it not for the fact that there are still members of the profession giving their patients medicines for reasons best known to themselves no doubt, thus deceiving the patient and eventually bringing reproach upon the surgeon because of the delay resulting from procrastination. So far as concerns electrical treatment, it cannot be successfully denied that some good results have been obtained in a small minority of properly selected cases in the hands of skillful electricians. However, the good results are so infrequent under the most favorable circumstances that we are justified in dismissing this remedy with quite as much emphasis as we do the medical treatment.

It is not my purpose to discuss the technic of hysterectomy and myomectomy. Every operator must exercise his own judgment in his cases. Personally, I am very partial to the total extirpation of the uterus in hysterectomy, unless there should be some extreme contra-indication.

Briefly, we may say that, all growing myomata should be removed as soon as possible, provided there are no extreme contra-indications, the result of other physical complications; when the tumors can be removed without extirpation of the uterus, it is desirable thus to operate, unless there are no reasons for the possession of this organ, and the danger to the patient will not be increast by its removal; young women should not be deprived of their uteri, except as a last resort; women of advanced age bear very well the operation for the removal of their uteri; patients in extreme flesh do not do so well under operations for uterine tumors as those in moderate flesh.

Finally: There should be no hesitation in the removal of the uterus for myomata in all cases where this organ has performed its natural functions and the woman is past the period of menopause, but all other conditions must be taken into account in giving opinion regarding the final recovery of the patient.

A NEW METHOD FOR REDUCTION OF STRANGULATED HERNIA.

BY H. C. OWEN, A. M., M. D., BALDWIN, KANSAS.

Before the day of carefully applied antiseptics, the operation for strangulated hernia was followed by a mortality of nearly 50 percentum; while antisepsis has lowered this percentage materially, deaths are still very frequent, especially with the aged.

The operation which I shall now report will, in my judgment, offer a lower mortality than attends the operation as now performed by the knife, as well as exempt the patient from the suffering which necessarily follows the usual operation. The simplicity of the operation, in its entirety, will doubtless commend itself to every operator.

TECHNIC.

The operation is performed as follows: The field of operation, hands and instruments are rendered aseptic. No anesthetic is needed. A trocar is selected which carries a canula, the lumen of which is about one line. The most dependent portion of the tumor is selected: If scrotal, the operator must see that a testicle is not in the way; then hold the tumor securely with the hand; with the right hand seize the trocar, letting one finger press firmly at a point indicating the depth to which it is wisht to pass the instrument; then at one quick thrust drive the instrument thru all the tissues and into the lumen of the bowel.

The instrument should always be past in the direction of the long axis of the bowel. The point of the trocar should be toward the opening thru which the tumor past out from the peritoneal cavity, so that if the bowel should be liberated and pass back into the abdominal cavity it could slip easily off the instrument without danger of tearing. Now, as the trocar is withdrawn the flatus quickly passes thru the canula, leaving the tumor quite soft with, in many cases, only a small amount of fecal matter to be removed. The next step is to attach a reversible pump to the canula and pump in a small quantity of warm sterilized water; then kneed carefully for a few minutes and pump it out: This is to be repeated until all fecal matter is removed from the incarcerated bowel. Leaving the canula remaining, it is next advisable to inject into the emptied bowel the following: Morphine sulphate, gr. ¼; water, 2 drams. The canula is now withdrawn and thirty minutes allowed to pass for the morphine to be absorbed, to control peristalsis, and swelling to close wound in bowel sufficiently to prevent leakage into peritoneal cavity after the bowel is returned.

After the proper amount of time has past the procedure is resumed thus: Elevate the hips, flex the thighs on the abdomen and apply taxis, gently, and the bowel will pass easily back into the abdominal cavity in a large proportion of cases.

I offer this operation as the easiest and quickest for the surgeon and the safest and most time-economizing for the patient. The patient need not lose more than one or two days from his business.

I have performed this operation twice: Once on Mr. Ed Ingals, of Media, Kan., and once on Mr. Wm. Foster, of Worden, Kan. The first patient rode on horseback on the second day after the operation. Neither suffered any inconvenience from the treatment.

Of course, where the omentum is known to be incarcerated, and where symptoms of gangrene have supervened, this operation is not applicable.

I believe that many cases of strangulated hernia, otherwise irreducible, could be rendered reducible by puncturing the tumor with the smallest trocar or exploring needle that would allow the exit of incarcerated flatus.

The operation which I have just described is, in my judgment, less dangerous than prolonged taxis with all its concomitants—such as chloroform anesthesia, the application of ice bags and hot poultices, etc., etc., all of which consume valuable time and help the patient to a more serious condition, provided reduction is not secured. Unscientific taxis, as applied by the inex-

perienced is more disastrous in strangulated hernia than even the operation by the knife in experienced hands. After free emesis occurs, and especially after it becomes stercoraceous, taxis promises but little in the way of hope of reduction, and may result in rupture of the bowel. When we, in the attempt at reduction, have applied all the force we could safely it is worse than useless to repeat the application of the same amount of force unless it be under changed and more promising conditions.

VESICO-VAGINAL AND VESICO-UTERINE FISTULAE AND THEIR CURE.

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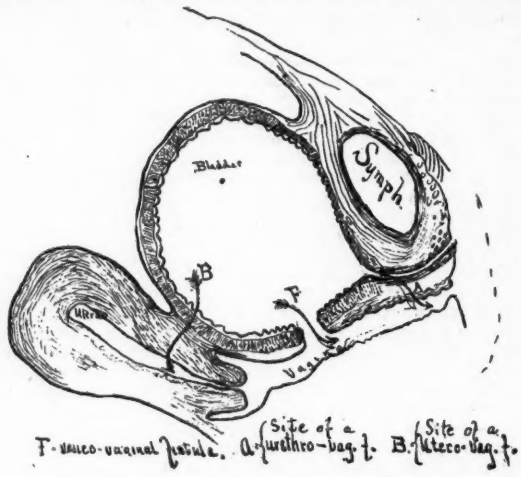
The physician who takes a woman, pregnant with her first child, from her husband's hands, in trust, and at the close of her confinement returns her as well, physically, mentally and morally, as when she first conceived, and with a healthy child to bear its father's name has accomplisht one of the grandest and best feats of medicine and surgery and should be rewarded by a fee that will compare favorably with that of a laparotomist or other major surgical operator!

Among the distressing accidents that follow tedious labor, prolonged delay in delivery, and violent and long continued pressure of the child's head, there is not one more to be dreaded than fistula from the genital tract into the urinary bladder. After a tedious labor, lasting perhaps 12, 16 or 18 hours, the forceps are applied and the child delivered by force; or perhaps this wise procedure is not employed and the time mounts up to 24, 28 or 30 hours of hard and exhausting labor, after which delivery is accomplisht naturally. The doctor finds next morning that the patient cannot pass urine. The catheter is used once or twice during the day, after which she passes it naturally, but with much pain, and with gradually developing evidences of cystitis. In five to ten days the urine breaks thru into the vagina and dribbles constantly thru a false passage. The vagina becomes irritated from contact with the urine; the thighs are excoriated and red; the smell of urine surrounds the unfortunate patient at all times, and she protects herself with cloths and pads to relieve her clothing from the unwelcome contact. She suffers in mind and believes herself an outcast; she shuns society. The doctor examines and finds a false passage between the bladder and vagina—a vesico-vaginal fistula; or perhaps urethro-vaginal fistula, or the urethra and vagina are normal and the fistula connects the body of the uterus with the bladder, a vesico-uterine fistula. The long-continued pressure has produced necrosis and ulceration of the tissues normally forming the septum, or else the forceps, tearing deeply, have wounded cervix and bladder wall and inflammation and ulceration have done the rest.*

The treatment of vesico-vaginal fistula is, of course, operative—to freshen the margins of the false passage and unite its edges by firm suture. But the task is not nearly so easy as this brief description would indicate. First of all we must be sure that sufficient time has elapst since the injury to allow of firm healing of the margins, so that uterine-infiltration does not take place into the tissues around our suture-line. From four to eight months are needed after confinement for this to occur; for altho other causes may be operative, yet over 90 per cent. of all cases of fistulae of this type come from prolonged pressure of the child's head during labor.

*Here I wish to enter an emphatic protest against the common tendency of the laity, and indeed of some physicians, who from their knowledge and training should know better, to ascribe the formation of a vesical fistula to the careless use of forceps or to some other mismanagement of labor. It is due, as stated, to the prolonged pressure of the child's head upon the soft parts, holding them firmly prest upon the pubic bone for such a time that the nutrition of the tissues is cut off and death of tissue results. It is often impossible to say when the forceps should be used to avoid dangerous pressure and all must be left to the judgment of the practitioner, who must here, as elsewhere, do the best he can under the circumstances. In no case should he be blamed for fistulous formation unless it is clearly shown that he neglected to do what he well knew should be done; for often a previous cystitis, a previous vaginitis, a deformity of the pubic arch or symphysis, a uric deposit in the bladder membrane or a malposition of the child, unknown and unknowable to the doctor, or a poor state of nutrition on the part of the mother, for which the doctor is in no wise responsible and which he can in no degree obviate, is at the bottom of the accident and renders its occurrence sure.

Then, too, the cystitis that is often present and the unhealthy condition of the vaginal mucosa require careful douching and prolonged administration of balsamics and other urinary antiseptics for their relief, as it is useless to operate in the face of such surroundings as an acutely inflamed mucous membrane will give. The next difficulty to be overcome is the embarrassment often experienced in removing scar tissue. Oftimes the uterus must be quite widely dissected off from the bladder and the relations of the two materially altered. Thus in one case upon which I operated in 1896: The anterior lip of the cervix had been widely split open and the tissues included between its gaping edges had slought away into the bladder. It was necessary to separate the cervix from the edges of the fistula and from the anterior vaginal wall and then to separate bladder and vagina, repair the bladder-



wall and afterwards the vaginal roof and restore the cervix below. Unfortunately there was so far non-union of the cervical tissue that a fistula of the cervix with the vagina existed, but the bladder wound was closed and has remained so thru a subsequent confinement. In another case the entire posterior wall of the bladder was destroyed between the trigone and the fundus, being drawn down and puckered about the opening into the uterus and cervix. A wide dissection was necessary before it was possible to close the cystic wall. In such cases there is much danger of opening the peritoneal cavity.

The woman should be prepared by careful attention to her general health; by rendering the vagina and bladder clean and free from inflammation; by rendering the urine bland and non-irritating and by having a healthy lower bowel, free from the results of indigestion in the upper tract and constipation in the lower tract.

The patient being under complete anesthesia, the edges of the fistula should be pared clean of scar tissue; the bladder, if need be, separated from the cervix or uterus to such a degree that the bladder opening may be repaired and brought away from the uterine wound; hemorrhage should be controlled by hot water and pressure, and adhesions and contractions separated until the edges can be brought together without tension. The sutures must be inserted so as to secure good grasp and hold well. They should not enter the bladder, but should catch the submucous tissue so as to approximate the edges of the mucous membrane. (With a vesico-cervical fistula it is often necessary to use the cervix to form part of the vesical wall.) They should be so arranged as to cause no serious tension; let the line be a semi-circle an H, a T, an angle, or S-shape, but always let the edges be brought together in the line of least resistance. Much depends upon getting the parts well into view and having them firmly held as to the success of the suturing.

In every case it is of prime importance to secure freedom from traction and tension upon the suture line by scar tissue, and to secure easy and close apposition of edges by suture. Particular care must be taken to keep away from the orifices of the ureters, and indeed from these tubes themselves when cutting and sewing.

It is always best to recognize the danger of non-union in all these cases and to have the patient's permission to operate a second time if needed. It will be needed often, as there is always a very large proportion of these cases when operated upon that require a second operation for their cure, for the first one often fails at some point. A long period—several months—is desirable

between operations for the same reason given for delay in the beginning, viz: To secure firm tissue as a ground-work for the suture lines, and complete reduction of any inflammation incident to the failure of the edges to unite.

I always feel safer with a soft rubber, self-retaining catheter in place and the patient turned as much as possible toward her face, for the first 48 hours. If no urine finds its way into the tissues for 48 hours, so much will be gained that healing per primam is to be expected. On the contrary, early infiltration and a subsequent closure by granulation leaves room for more frequent failure. A frequently repeated carbolized vaginal douche is beneficial after the second or third day up to which the wound is supported by a firm pack of gauze.

As to suture material, I am not an authority. I have used silver wire, silkworm gut, silk and chromicized catgut—the last I cannot say how successfully, as the date of the operation is too recent. I cannot believe that much depends upon the suture material used, if one is careful to secure free dissection of scar tissue from the parts, good denudation and close suturing and to avoid passing sutures thru the vesical mucosa into the bladder. More will depend upon the method of insertion than upon the material inserted, altho silver wire certainly has the best recommendation as a suture at the present day.

A word as to primary cure. This should always be tried for by the surgeon who sees a case of this kind when the edges of the opening are still raw. There is no doubt in my own mind of the fact that many cases are spontaneously cured by closure by granulation of the opening. I recall two cases in my own practice that bear out this theory and certainly there must be many more. The first case was that of a boy who fell from a barn loft onto a pointed picket. The picket entered to the right and in front of the anus close to the margin of the mucosa and skin, ruptured the sphincter, lacerated the bowel for some two inches and wounded the bladder so that urine came from the wound. The lower bowel was cleaned, and the wound packt with aristol and gauze. After a rapid convalescence the bladder wound was found closed and he recovered entirely. The second case was one seen in consultation with a physician of this city, in which there had been a fall of some 25 feet and severe laceration of the pelvic tissues. Blood was past from the bowels, and also from the bladder and urine found its way directly from the bladder into the vagina. Upon examination some time later when it was possible, a long scar was found extending across the anterior vaginal wall perfectly healed. There was no permanent fistula. These, to be sure, were both traumatic cases. The following, however, was not: Dr. Carlock reported at the meeting of the Southwestern Missouri Medical Association in April last a case of vesico-vaginal fistula in which the flow of urine was brought to his notice about two weeks after confinement; he cleansed the vagina and bladder well and inserted several sutures of catgut and was rewarded by an immediate union. This, of course, is an unusual result, but in the light of the benefit secured worth trying for.

CORNUAL PREGNANCY.*

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The Fallopian tubes and the uterus are derived from the Muellerian ducts which appear quite early in embryonic life in the ventral edges of the Wolffian bodies. While the upper parts of the Muellerian duets (which permanetly remain separate and distinct) develop the tubes, the lower half of these ducts by their blending develop the uterus. Deviations from the normal process of blending may and do give rise to a variety of anomalies and malformations of the uterus, of which a few may be mentioned. The two parts may be developt equally, but the junction may not be complete, leading to the condition of uterus bicornis unicollis, either horn of which may become pregnant, and be delivered of a normal child at full time. In another class of cases one horn is well developt, and the other only partially, being attacht to the first one by means of a pedicle which may or may not be provided with a pervious canal leading into the cervical canal.

Cases of pregnancy have been reported in which neither a sound could be past through the pedicle, nor could careful microscopical examination detect any signs of a preexisting canal. Walthard's case is one in point where he specifically states that "during operation and section the finest sound could find no communication of the sac with the uterus, nor could microscopical section."

*Abstract of paper read before the Chicago Gynecological Society, April 21, 1899.

Pregnancy undoubtedly has often occurred in the undevelopt horn; Kussmaul, as early as 1859, was able to detect twelve cases of this sort; to these Saenger in 1883 added fifteen cases, and in 1888 Himmelfarb found seven more cases, making in all 34 cases at that date. In 26 of these the fetus died before the middle of pregnancy. In 24 of the cases rupture of the horn occurred and caused maternal death. In an article by Cullen and Wilkins in Johns Hopkins Hospital Report for 1897, the statistics given show that in the 39 cases of cornual pregnancy collected by them, not a single case which ruptured failed to die very promptly.

This is the usual history of cases of cornual pregnancy in a very large percentage of all the cases of this variety. They go on to about the fourth or fifth month when rupture occurs and death follows. This, it will be noted, is somewhat later than in tubal pregnancy. The case observed by Cullen and Wilkins, which formed the basis of their report, died about two hours after the beginning of the symptoms of rupture, and before surgical help could be procured. So far as my own searches in the literature go they confirm this statement. With the exception of Massen-Slavjaensky's case I have been able to find no cases reported which were operated after rupture took place, and this case died on the fourth day of general peritonitis.

Cases, however, which were operated on before rupture occurred, have given most excellent results. Of the 26 cases which I have found, twenty-two of them have made good recoveries, or close on to eighty-five per cent. In view of these facts it behooves us to make as early a diagnosis as possible, and remove the offending horn. If we may fairly judge by Cullen and Wilkins' case, it would be almost impossible to prepare a patient for operation before a fatal result occurred. The hemorrhage from such a rupture would be much greater than from the average rupture of a tubal pregnancy, because of the larger vessels probably involved, and the fact that in a typical case the horn is free and moveable and the bleeding is favored in consequence.

The anatomical conditions that are found in these cases vary from a case like Riedinger's (where the pregnancy took place in a uterus which showed no external signs of being bicornuate) to a slightly grooved condition of the fundus, or a widely separated horn which is connected with the rest of the uterus and the cervix by a fleshy pedicle which might or might not have a canal leading into the cavity of the cervix. If a canal had existed in the pedicle and become obliterated prior to the occurrence of pregnancy, how was the menstrual flow disposed of, and why has there not been formed a hematometra from the retained blood and as a result the impossibility of pregnancy taking place? It is not known positively whether the rudimental horn menstruates or not. The case of Hoepfl is of some interest in connection with this point. In this patient a fistula was formed by uniting the edges of the sac to the abdominal incision and a surface of the sac 10 cm. by 5 cm. was left exposed; altho the fistula remained open for some ten months, and the patient menstruated during this period, there was never any discharge of menstrual blood thru the fistula. If the impervious condition of the pedicle had existed at the time of conception, of course this could have taken place only by one of two methods. Either the spermatozoa past thru the developt horn and its corresponding tube, and thence across the pelvic cavity to fertilize an ovum on the side of the undevelopt horn; or else the spermatozoa fertilized an ovum on the developt side which in some manner found its way across the pelvis to the rudimental horn. The corpus luteum verum was found in such a large proportion of cases reported to be on the side opposite the pregnant horn, that it seems that we must accept this as a possible mode of impregnation. The experiments of Leopold seem to prove conclusively that, in dogs, at least, it is possible for the ovum to pass across the pelvic cavity and enter the tube on the opposite side. By removing the ovary on one side, and tying off the tube on the opposite side, pregnancy still took place in a number of animals on which he experimented. In at least eight cases of those we have histories of the corpus luteum verum was on the opposite side from the pregnant horn.

On account of the well-known mobility of the spermatozoa, it is not difficult to understand how they might pass across the pelvic cavity from the well developt to the rudimental side; but how an ovum can cross over from the ovary of one side to the tube on the opposite side is not so easily comprehended. It is true we do not know how close together the two ovaries are lying in the pouch of Douglas prior to the occurrence of conception.

It has been stated by some writers that in these cases pregnancy occurs oftener on one side than on the other, the right side being usually the one thought to be the more common. We have found in the cases reported fully enough to show which side is involved that the figures of the two sides are almost equal, there being twelve on the right, eleven on the left, and three in which the side is not given. The largest number of cases have

occurred in the first pregnancy, being eleven out of twenty-six. Five cases occurred in the second pregnancy,two in the third, two in the fourth, and one case in the fifth. The other cases were not specified. The average age of the first pregnancies was 23 years, of which the oldest was 29 years, and the youngest 18 years.

Among the 26 cases, as before stated, there have been 22 recoveries, and 4 deaths. Of the four deaths we have the cases of Litzmann-Werth, Massen-Slavjaensky, Remfry and Owen. Werth's case was already septic when operated, and died two days later of peritonitis. This case had been diagnosed as retention of full-term putrid fetus in utero. Massen-Slavjaensky's case died on the fourth day of general peritonitis. This was a case of rupture of the pregnant horn at about the fourth month, and it is the only one we have found which was operated after rupture took place. Remfry's case died on the ninth day of shock. In this case the patient did well, and the stitches were removed on the seventh day, and apparently primary union had taken place. On the eighth day, after a severe fit of coughing, the wound was discovered to have gapt, and the intestines had protruded under the dressings; she died the next day of shock. Owen's case was unique: the abdomen was opened, and a cornual pregnancy was found, the pedicle of which was open in the cervix. The canal of the pedicle, however, was bent downward into the pelvis, and then turned upward to reach the cervix. After pulling up the pregnant horn an assistant could introduce his finger thru the cervix into the canal of the pedicle to feel the presenting part. The operator contented himself with simply raising up the pregnant horn and then closing the abdominal incision. Two days later the six-and-one-half-months' fetus was delivered thru the natural passages, and four days later the mother died.

Of the cases which recovered, Saenger's case gave birth to two living children some time later, Gummert's patient had a child fourteen months later with normal confinement, Walthard's patient had normal labor eleven months after operation, and my own patient is probably pregnant since about November 5, 1898. Serejnikoff's patient was delivered by the operation of a live child which lived some six hours. This is probably the only case recorded where a living child was delivered from a rudimentary horn. Gummert's case was a simultaneous intra-uterine and cornual pregnancy combined, and was diagnosed as a threatened abortion at the third or fourth month, and a dermoid cyst of the left ovary.

The cases which I have tried to get together were those which have been operated upon, and of course the cases which have ruptured and resulted fatally to the mother have not been included. That a large percentage of these result in rupture and death is shown in the thirty-four cases mentioned above as having been collected by Kussmaul, Saenger, and Himmelfarb. In the operated cases we can divide them into two classes, the first and larger class being the cases which went to full term or later, and the second or smaller class being those which were diagnosed and operated previous to the seventh month of pregnancy. Of these two classes, in the 26 cases we have collected, there were 14 belonging to the first, and only 6 to the second class. In the other 6 cases the detailed reports were not sufficiently complete to enable us to decide as to the exact period of pregnancy.

As regards symptomatology, in the first class, as a rule menstruation stopt and symptoms of pregnancy supervened. To the stoppage of menstruation there was but a single exception and that in the case of Mangiagalli, and in this the flow continued to be regular, but scanty. In all the other cases menstruation stopt entirely for a period varying from four or five months to ten or eleven months. Macdonald's case did not menstruate for eleven months, and Rosthorn's case for thirteen months. As pregnancy proceeded there was the usual gradual enlargement of the abdomen, nausea, vomiting, dental neuralgia, usually more than ordinary pains in one or the other side of the lower abdomen which did not always attract attention, pigmentation of linea alba, enlargement and fullness of the breasts with presence of colostrum in a fair proportion of cases, and frequently the typical changes in the nipples and areolae. Patients in some cases "felt life," and the examiner could distinctly auscultate the fetal heart or outline the fetal parts by the abdominal palpation. As time went on and date of expected labor arrived, a large proportion of these patients were taken with pains lasting for a variable period and eventually passing away. In the nine cases reported by Macdonald, Galle, Salin, Walthard, Hoepfl, Riedinger, Schramm, Wiener and Serejnikoff it is specifically stated that pains occurred at the end of pregnancy. After the disappearance of the pains for a variable length of time the patients would again begin to complain of pains, and these, frequently with the development of septic symptoms, led them to seek surgical advice. More careful examination now being made disclosed the facts that the mass was lying on one side of the pelvis, and that the true uterine cavity was empty. Bimanual examination showed in most cases that the uterine body was lying decidedly lateroverted to the side of the pelvis opposite the pregnant horn, passage of a sound to the fundus showed the uterine cavity to be empty and frequently the lateral mass could be demonstrated to connect with the uterine body by means of a fleshy pedicle at about the level of the internal os. The tumor was usually oval, and occupied a diagonal axis in the abdomen. According to Hoepfl, Kuestner says: "The rule (that almost always beside the sac a distinct corpus uteri is easily to be felt extending upwards from the point of junction of this with the uterus or cervix) is not without exception; if the bicornuate condition is less developt, or if the point of junction of the rudimentary horn lies very high, then it is not possible to separate the non-gravid horn distinctly form the gravid horn."

In spite of what appeared in many of the cases to be clear histories, all sorts of mistakes in diagnosis were made. Thus in Angus Macdonald's case where with what appears in reading to be clear history of pregnancy a diagnosis of fibroid was made, and the actual character of the tumor was discovered only after getting into the abdomen. Most of the cases were mistaken for pedicled myomas or ovarian cysts and very few cases were correctly diagnosed. Saenger looks upon the intermittent contraction and relaxation of the sac as being characteristic of cornual pregnancy, and so it might be if found, but it is very apt to be absent. Landau speaks of it as being of little moment, and Walthard especially states that in his case neither hardening from contraction nor softening could be demonstrated. This symptom is apt to be absent in a large proportion of cases on account of thinning out of the musculature as the horn is distended. Kuestner considers the presence of decidua in the uterine cavity as a distinguishing sign of tubal pregnancy, and Bland Sutton in his book on the "Surgical Diseases of the Ovaries and Fallopian Tubes," publisht about 1891, says: "In tubal pregnancy, a decidual membrane forms, not in the tube, but in the uterus; in bicornuate uteri the decidua is formed in the impregnated cornu." These statements are not strictly true, because observers have seen decidua in the pregnant tube, and also in the non-gravid horn in the cases of cornual pregnancy. The latter was observed by Wyeth in his case.

In the class of cases where the condition is discovered during the earlier months, the diagnosis is much more difficult on account of the absence before the fifth month of any of the positive signs of pregnancy. Leopold, in the discussion of Saenger's case, says that in the first six months diagnosis is very difficult without an exploratory laparotomy. Another writer says that the diagnosis of this condition is only a fortunate accident. Of course the extreme rarity of this condition, and our almost complete unfamiliarity with it makes the diagnosis exceedingly obscure. Serejnikoff, quoting from Schrenk, says that among cases of extra-uterine pregnancy, the cornual pregnancies compose only 3.6 per cent. In a typical case as in my own it seems as if a little more knowledge would enable us to make a diagnosis, or at any rate a very strongly probably diagnosis. Given a mass in the lower abdominal region following the cessation of menstruation and all the ordinary symptoms of beginning pregnancy, and corresponding in size to a pregnancy of date indicated by the last menstrual discharge, and in which we find the uterine cavity empty and the body prest to one side of the pelvis, and the mass connected with the uterus by a fleshy pedicle at the level of the internal os, our suspicions as to the true character of the condition should be strongly awakened. At any rate our suspicions as to an existing pregnancy should be aroused, and the physical signs will enable us to make at least a probable diagnosis.

We should expect in the first place an amenorrhea, and this has been the case with a few patients (only six) which have been reported, with the exception of Landau's, where menstruation took place every six to eight weeks, as before conception occurred. Then we expect to find nausea, vomiting, fullness and enlargement of the breasts, changes in the nipples and areolae, and possibly pigmentation of the linea alba. Bimanual examination will disclose the uterus lateroverted, sounding will show the uterine cavity to be empty, and a mass of variable size will be discovered connected by a pedicle with the uterus usually about the level of the internal os. Sometimes, or perhaps as a rule, the uterine cavity may be increast in depth from 1½ to 3 cm., and the cervix may be softened and somewhat patulous. Discoloration of the vagina and cervix may or may not be present. A sign which was very striking in my case was in the extreme mobility of the mass, much more so than could be the case except in this condition or that of an ovarian cyst or fibroid with a very long pedicle. This exceptional mobility was noticed in several of the cases reported, as in that of Macdonald's, who speaks of the markt lateral mobility of the mass. Landau also speaks of the

free mobility of the tumor in his case the first time he examined it. Given a probable extra-uterine pregnancy, we may safely diagnose it from a tubal gestation, as it is probably very unusual to find a pedicle tubal pregnancy; Wiener also looks upon the mode of connection with the uterus as a very important point of the diagnosis, saying: "Thru the mode of connection with the uterus perhaps horn-pregnancy may be differentiated from interstitial pregnancy, as in the former the pregnant horn is united to the other horn by a longer or a shorter pedicle almost never at the upper portion, but as a rule in the region of the os internum, while the latter is joined broadly to the uterus. Besides this as the interstitial pregnancy increases in size it draws the whole uterus up with it, as in the case in interparietal growths located on the fundus, while in horn pregnancy this is not the case, or if so, to a small extent."

Landau, whose case was unique as the fetus died very early and changes took place as the result of such death, speaks of these changes as follows: "The previously smooth, tense, elastic tumor was decidedly smaller, harder, more uneven, and less movable. It lay still deeper in the pelvis than before and depressions were easily recognizable on the surface. To the left and behind the tumor was to be felt a body like an ovary lying close to it. The relation of the tumor to the uterus and the position of the latter was unchanged." He says further: "As to the diagnosis this could not be made with certainty, altho the woman was examined on three different occasions. When the first-time pregnancy (intra-uterine) was diagnosed it was impossible with the most careful examination to differentiate the uterus, bent sharply to the right, from the pregnant horn lying close to it and filled with fluid contents. At the examination fourteen days later intra-uterine pregnancy must be excluded as one could not very distinctly and separately feel the small uterus in the right pelvic half; not a single sign spoke in favor of the tense, elastic tumor being an extra-uterine pregnancy. On the contrary, its extensive mobility and the palpation of the pedicle made one think only of a pedicled ovarian cyst or myoma." He thinks, however, that perhaps the changes, such as took place in the consistency of this mass may be of value in diagnosing parallel cases in the future. The tumor, at first tensely elastic, later became solid. "When we ask what kind of growths may undergo such changes as are necessary to produce the conditions, the only answer we can give is that they are such encapsulated tumors as contain fluid and blood, the latter clotting and the fluid part being absorbed. Further, what conditions are these that offer such combinations, blood in preformed space? Only extra-uterine pregnancy and hematocele. Of growths which vary in size or consistency there are several, as hydrosalpinx or hydronephrosis; perhaps, also, changes are observed in many myomata, also the consistency of myomata may vary according to whether they are examined during menstruation or in the interval. Ovarian cysts with twisted pedicle change in size, only here there is never any change in consistency, even with severe bleeding, as only the blood and not the fluid coagulates. That a previously cystic swelling becomes smaller and hard can only be true of encapsulated blood tumors. This can only happen where the wall does not tear, but remains encysted. For cases in statu nascendi in the true sense of the word this sign has no value. Here it will depend on whether one can recognize the fact of an ectopic pregnancy at all, and if this can be done can one recognize a horn pregnancy? I think that with simple vagina and single cervix it will very seldom be possible." It might be well to add that in none of the 26 cases collected has any note been made of duplicity of either vagina or cervix, tho of course if either of these conditions were found our suspicions would be much more readily excited.

In regard to treatment there is only one method to adopt, and that is to remove the undevelopt pregnant horn as soon as a diagnosis has been made. It should be removed in toto wherever practicable. If too many adhesions interfere with the complete removal of the sac, it should be trimmed off as much as possible and the edges united with the edges of the abdominal incision.

The history of my own case is as follows: Mrs. A. S., 23 years of age, Swede, presented herself at my clinic June 6, 1898. She had been married one year and a half. No children. Said to have miscarried some time in January, 1898; but she had no physician, and the abortion may be doubtful. Always regular previous to marriage, and up to within six weeks of the supposed miscarriage. When she presented herself at the clinic she had not menstruated for four months. She complained of an abdominal mass in the right iliac region, which had first been noticed about two weeks previously. Both she and her husband stated that when first discovered it was about the size of a goose egg, but had increast very rapidly since then, so that when I first saw her it was the size of an average full-time fetal head. The mass was painful and sensitive to pressure, she complained of some morning sickness, and the areolae of the nipples were somewhat darker than normal. The temperature was 100 degrees F., under the tongue. Physical examination thru the abdominal wall showed an exceedingly movable mass which could be pusht freely into almost any part of the abdominal cavity, tho when left alone it always gravitated back into the right iliac region. The mass was ovoid in shape and in quiescent position its long axis was diagonal to the long axis of the body. It was difficult to tell whether its contents were fluid or solid. Patient had no urinary symptoms and bowels were perfectly regular.

Bimanual palpation showed the uterus crowded decidedly to the left, somewhat larger than normal, and also a slight degree of softening of the cervix. Color of vagina and cervix was not noticeably altered. By having assistant pull the mass up toward the ribs a pedicle could be felt connecting the uterus on the right side well below the fundus.

The diagnosis of cornual pregnancy was discust, but was excluded on account of the history of rapid increase in size, and the extreme mobility which at that time I considered too extensive to accompany this condition. A diagnosis (or possible diagnosis) of ovarian cyst with twisted pedicle was made on account of this same increase in size, tenderness, pain, and temperature. In making this diagnosis too much stress was laid upon the statement of the patient as to the rapidity of increase in the size of the tumor, which could not have been growing any faster than a normal pregnancy. The diagnosis should have been based more on the menstrual history and the signs obtained by bimanual examination. A correct diagnosis could be made almost positively in a parallel case.

The patient was operated upon a few days later. On opening the abdomen the mass presented at incision was apparently a cyst, and as there were enlarged blood-vessels running across the surface, the diagnosis appeared to be confirmed. A trocar was plunged into the tumor and some ounces of fluid were withdrawn. The flow of fluid soon ceast, and then the true condition of things was recognized in attempting to deliver the sac. The sac at this point was very thin and friable, and tore readily in the efforts to remove it. Placental tissue and fetus were delivered before the sac was turned out. The sac was amputated well down to the internal os. The pedicle was rather broad and was tied off in about three sections, when the stump was buried under the peritoneal layer. The left cornu was enlarged to about the size of a six-weeks' pregnancy, and during the next few days shreds of membrane were past per vaginam. These were probably decidual membrane, but were so completely degenerated at the time they were discovered as to make a microscopical examination impossible. The patient's recovery was absolutely uneventful.

A CASE OF LARGE TUMOR OF THE BRAIN, PRODUCING FEW SYMPTOMS SAVE OCULAR CHANGES, WITH REMARKS ON THE VALUE OF DOUBLE OPTIC NEURITIS AS A SIGN OF BRAIN-TUMOR.*

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The subject from whom this brain was removed was Dr. W. B. DeV., aged 51, who was brought to me July 21, 1898, by Dr. Frank J. Tainter, of Warrenton, Mo. The following history was given:

Patient had typhoid at 10 years; has had rheumatism for last 7 years. For 20 years has had attacks of supraorbital neuralgia, always on the right side. For 12 or 14 years has had reflex vomiting with no regularity about it. Has never had syphilis. For last 4 days has had great pain in the back of the neck. On lying down this pain is worse. Patient says, "To concentrate my sight or to concentrate my thoughts, brings on pain over the right eye. I feel distracted at times." Pain is greatest over right cerebellum. At times there are rheumatic pains in arms and legs. No bladder or rectal symptoms. He is constipated, and stumbles in walking.

The patient was brought to me on account of failing vision. I found that he began to wear glasses 12 years ago and used the same pair continuously since. He had complained of diplopia, both vertical and horizontal, for 7 or 8 weeks. There was no paralysis of any ocular muscle at the time of my first examination, altho the right external rectus was paretic. The pupils were small and sluggish. Vision was as follows: R.E.=15-100; L.E=

*Read before the Missouri State Medical Association at Sedalia, May 19, 1899.

15-100; with +1.00 combined with + .50 axis 90 degrees= 15-40. The ophthalmoscope showed a markt condition of double choked disc.

The patient was seen by several neurologists, general practitioners and surgeons, and each man made a different diagnosis. Dr.B.considered it a case of"chronic vertical meningitis" and gave an unfavorable prognosis. Dr. M. considered the case one of cerebral syphilis and promised to cure the patient. Dr. L. looked upon it as a case of abscess of the brain. I was obliged to disagree with these gentlemen, and regarded it as a case of brain-tumor, but was not able to locate the lesion, and gave an unfavorable prognosis. In deference to the advice of the neurologists I followed out the treatment suggested by them, viz., large doses of iodide of potash and mercury.

On July 24, three days after the first visit, the patient became suddenly blind. His local physician kindly wrote me from time to time, and from these letters I am able to give the history. Under date of August 3, Dr. Tainter wrote:

"The following Sunday after you saw him (being two days) he awoke noticing that a material change in the loss of his eyesight was manifest since the previous evening. He told his wife that before night he would be blind, and true, he was, since which time he is unable to distinguish any object, not even a lighted candle at 3 inches. He imagines at times he sees groups of people, stars, etc. He is unable to tell in what direction sound comes from. After arising from sleep, seated on the edge of the bed he is unable to tell which end of the bed contains the pillow. He will usually attempt to get out of bed to the left side—which is against the wall. There is a bilateral iridoplegia, pupils both about the same size, measuring 4.5 mm. His gait is unsteady. There is impaired co-ordination while standing. The last two days he complains of a sense of pressure upon the extreme ends of the fingers of the right hand. I have been pushing the iodide and mercury under which he suffers less, practically nil. With the assistance of from one-fourth to one-eighth grain of morphine he sleeps well."

On August 18 Dr. Tainter wrote:

"Your letter of 16th received. I have been sick myself, today being the first time I have seen Dr. DeV. since I wrote you some 10 days ago. I found him this morning feeling much the same, perhaps more pain in the head than usual. He sees absolutely nothing. His temperature this morning, as has been characteristic thruout, was subnormal. It ranges between 97 degrees, 97½ degrees and 98 degrees. Pulse is slowly weakening; three weeks ago it was 80, later 85, then 90; this morning 100. While it is uniform in rhythm it lacks in volume. The patellar reflex is entirely abolisht; the pharyngeal reflexes are still normal. He still complains of a 'pinching' in third and fourth fingers of right hand, extreme ends; also some slight 'pinching' in the first and second fingers of the same hand, but not so acute as in the other fingers. He is emaciating perceptibly. The pain he complains of he refers to the supraorbit and base of left side. His appetite is fair and digestion fairly good."

On August 22 the patient was again brought to my office. I found him as described in the foregoing letter. The pain, however, was now referred to the right parietal region and to the base. The pupils were dilated one-half, with small response to convergence. Vision was absolutely lost. The ophthalmoscope showed choked discs. Patient has never had a convulsion.

It being evident that medical treatment was doing no good, the question of surgical intervention was considered, and I advised it, altho I well knew the difficulties surrounding the diagnosis. Instead of submitting to operation, patient was taken to his home and on September 1 I received a long letter from Dr. Tainter. It is unnecessary to quote this in full:

"After his return from St. Louis he felt better, slept well all night and the pain in his head was not so severe. Temperature 98 degrees, pulse 90 degrees. Paralysis of external rectus of right eye; patellar reflex abolisht; pupils larger than two weeks previously, measuring 5.5 mm.; reflex iridoplegia of both eyes; sense of numbness in fingers of right hand; no perceptible exophthalmos. Used one dram of mercurial ointment by inunction and am giving syrup of hydriodic acid."

This treatment was continued with the addition of sodium bromide to produce sleep, without any particular change until September 4, when the record shows that he was in a half comatose state, pulse 62, temperature 97½ degrees. Polyuria was now manifest with abundant phosphates, but no other abnormal constituents. The specific gravity was 1.008. His condition gradually grew worse.

On September 11 he was operated on by Dr. Lanphear, the skull being opened on the left side. An excessive amount of cerebrospinal fluid was found and nothing more. The operator wisht to open the opposite side, but the patient was in no condition to stand further intervention. He died in a few hours.

The post-mortem examination, made on September 11, showed the presence of a large tumor on the right side which grew from the dura over the opercula of the island of Reil. Microscopic examination showed this to be a sarcoma of the spindle-cell variety. The tumor measured 7 cm. horizontally, 3 cm. in thickness, and 5 cm. vertically. The tumor was clearly defined from the brain structure. I removed the optic chiasm and the posterior one-third of the left eye-ball. There was markt distention of the intervaginal space by serous fluid. The microphotographs show thickening of the dural sheath of the nerve, and the usual swelling, increast vascularization and round-cell infiltration accompanying choked disc.

Since the case of Dr. DeV. was seen by some of the ablest diagnosticians in St. Louis, and puzzled them, I deem it only fair to the surgeon who operated that his views be inserted here. Dr. Lanphear has spoken of the case as follows:

SURGICAL ASPECTS OF THE PRECEDING CASE, BY DR. EMORY LANPHEAR.

There are three aspects of this case which need more careful consideration than they have received in the report of the essayist. The first is in relation to the differential diagnosis; the second, in regard to the peculiar symtomatology, and third in regard to the surgical treatment.

1. Relative to the differential diagnosis. The symptoms in this case were such as to lead one to believe that the trouble was an abscess rather than a tumor. There was a history of the middle-ear disease upon the left side, which, next to trauma, is the most frequent cause of cerebellar abscess and cerebral abscess.

The headache which he had was severe and continuous; it was not that peculiar headache which is characteristic of tumor; that is, one which is intensified by the slightest movement, which is so violent as to cause the patient to believe that his reason is tottering and which is increast by tapping the skull. Then it was located chiefly upon the left side, at least during the time I saw the patient, and was not diffuse.

He complained of disturbed sleep.

There was paralysis of the abducens, a condition which is rare in cases of brain-tumor, but is a particular feature in cerebral abscess, according to Wernicke.

There was that long period of subnormal temperature, which also is characteristic of intracranial suppuration.

Against tumor there were also two or three points:

1. There was the absence of a cerebral vomiting, except reflex vomiting, from which he had suffered for 12 years. Now, we know that cerebral vomiting, next to papillitis, or choked disc, is the most prominent feature of brain-tumor.

2. There was the absence of convulsions, which is the second most important and prominent symptom of brain-tumor, according to Hirt.

3. There was absence of paralysis, except of the abducens and, later, of the hypoglossal; the first of which (the paralysis of the abducens) would point to abscess of the temporosphenoidal lobe, and the second (paralysis of the hypoglossal), to abscess of the cerebellum.

In favor of tumor, the diagnosis which was made by Dr. Ball, there were three or four things:

First, he had choked disc; but this is not of necessity a symptom of tumor of the brain, because we find it in other conditions where there is increast intracranial pressure as well as changes of the condition of the blood; moreover, the choked disc was very rapid in its appearance, judging from the clinical history of the case, leading to sudden blindness, which also points to abscess rather than to tumor, because it is a rule in intracranial surgery that the larger the abscess and the more rapid its development, the more markt are the symptoms of intracranial pressure, including, of course, all the symptoms of trouble within the brain. The second point in favor of tumor was the headache, but as I have already said, that was in its peculiarities rather indicative of abscess of the brain than of tumor. Third, the absence of the early fever, which we would expect to find in abscess of the brain, whether due to trauma or middle-ear disease; but unfortunately there was a cloud upon the early history of this man because he had not come under observation of Dr. Tainter until very shortly before he brought the patient to Dr. Ball on account of the blindness, so we were not sure that early fever did not exist. A fourth point in favor of the tumor was the slow pulse, which persisted until very late. It is well known that in tumors the pulse at first is very slow (40 or 50), but that the retardation is soon followed by an increase, that is to say, the primary irritation of the vagus gives rise to or is followed by a partial paralysis of the vagus.

Second, in regard to the peculiar symptoms which were present: First, there was a peculiar absence of localizing symptoms until very late; and they pointed to the wrong side. This was the chief peculiarity of the case: all the localizing symptoms pointed to lesion upon the left side rather than on the right side. The sec-

ond point which is peculiar is that a tumor located as this is seen to be, impinging very much upon the lower part of the Rolandic area, should not have given rise to convulsive movements of the opposite side, for here we have a tumor of such size and location, so pressing upon the motor cortex, that is must have caused very great irritation of the lower Rolandic region, particularly that which presides over motion of the face, and tongue, and lips. The symptoms which, later on, were of such localizing character as to indicate a lesion upon the left side of the brain were: The paralysis of the tongue, the paralysis of the external muscles of the eye on the right side, a pain upon the left side of the head, and later, numbness and tingling sensation of the fingers of the right hand.

Third, referring to the surgical aspects of the case. What were the reasons for trephining? They were three in number. First, to perfect the diagnosis. There was, as the essayist has said, a diversity of opinion on the part of all who had seen the case. While I made a tentative diagnosis of abscess, I was not even at first convinced positively that it was abscess and not tumor, as Dr. Ball contended; later on I came to the conclusion that Dr. Ball was right, and for that reason operated, but it was also to satisfy all of the other physicians connected with the case that it was either a tumor or abscess, and not the things which had been pronounced to be by the neurologists. Second, to relieve the intracranial pressure, and third, to remove the tumor if it were found.

Now, why was the left side chosen? First, because the only localizing symptoms were such as pointed to the left side. Second, he had had an ear-trouble upon the left side for some years before, which pointed to a possibility of the lesion of the temporosphenoidal region (or a little higher) from the middle-ear affection, or to abscess in the cerebellum. Third, the pain was finally located on the left side. Fourth, the right external rectus was paralyzed. Fifth, we put him upon the table with the idea of opening the opposite side of the head, if the lesion was not found in the part of the brain to which the few localizing symptoms that were present seemed to point. When a large part of the left side of the skull had been removed by osteoplastic resection in the parietal region, it was possible to explore the entire hemisphere of the cerebrum very well, reaching forward as far as the frontal convolutions and backward to the occipital region, and it was soon demonstrated there was no lesion on that side of the brain above the tentorium cerebelli. With the possibility of abscess still in mind I took the trephine and opened over the middle lobe of the cerebellum upon the left side. The reasons why this was done were these: There was no lesion above the tentorium cerebelli upon that side; second, the early blindness—early, relatively (he became blind soon after he fell into the hands of the doctor, and Hirt says this is always to be interpreted as a focal symptom pointing to lesion of the cerebellum); third, because the cerebellum is a frequent site of abscess following middle-ear disease.

It was suggested by someone that lumbar puncture be made: First, for the purpose of eliminating meningitis; and second, for the purpose of relieving intracranial pressure. I object to this procedure—first, because the drainage is not permanent, the cerebrospinal fluid being of such a character that it is very rapidly formed; it would therefore entirely relieve intracranial pressure only for a few hours, so that if permanent lumbar drainage is not establisht (which has not yet been done), it would give only temporary relief; second, because it is an operation not entirely devoid of danger; and third, because it is valueless as a therapeutic measure, being only of value from a diagnostic standpoint as a means of eliminating suppurative meningitis.

The case, above all things, proves the correctness of Hirt's assertion, that, especially in tumor, a local diagnosis should only be attempted with the greatest circumspection, and even then errors cannot be altogether excluded.

In this connection I wish to say that I regret very much that the patient did not come into the hands of an operator at an earlier time than he did. At the first visit Dr. Ball and myself both urged the patient to submit to an exploratory operation upon the head. I believe that the fair physical condition which he presented at the time of the first examination was such that it would have been possible to open both sides of his head safely; and if the right side had been opened this tumor was in such a location that it certainly would have been within the field of surgical intervention; and judging from the postmortem condition of this brain, I am satisfied that with one item (severe hemorrhage) alone excepted, it would have been a very easy operation to enucleate and remove this sarcoma. It is possible that with the large blood vessels which supply this tumor the hemorrhage might have been so severe as to interfere with the operation. In one case of very similar character, tho the tumor was not quite so large size, I was compelled to desist in my attempts at removal of the neoplasm on account of the bleeding from the large vessels which would not yield to any method of ligation or clamp, but simply tore in two as far down as one could reach; the consequence was, I had to pack the skull tightly with iodoform gauze, without removing the tumor, in order to keep the patient from bleeding to death. It is barely possible such a disaster would have occurred in this case, but from the ease with which the tumor may be lifted from its bed in the convolutions I am of the opinion it might have been possible to remove it had the patient permitted operative interference at an early stage of the trouble, instead of waiting until practically in articulo mortis.

REMARKS ON THE EYE-SYMPTOMS OF BRAIN-TUMOR, BY DR. BALL.

Since it was by the eye-symptoms alone that I made the diagnosis in the case just mentioned, it may be profitable to discuss this subject.

The eye-symptoms in brain-tumor are numerous and they comprise not only paralysis of the third, fourth and sixth nerve, but as well unilateral or bilateral exophthalmos from pressure on the cavernous sinus; changes in the fundus; the condition of the field of vision, as regards its concentric limitations and as regards the presence of hemianopic contraction; and, finally, visual acuity.

The eye-symptoms in brain-tumor can best be divided into two classes: Changes in the fundus of the eye, and derangements of sight. The evening is too far gone to consider all these, but if you will permit, I will take up a few moments in considering the changes in the fundus. Of all the signs of brain-tumor the presence of double optic neuritis is the most valuable for three reasons: In the first place, it is an objective sign. The optic nerve is the only nerve in the body which can be examined while the patient is alive without dissection being made. Second, in 80 per cent, or, as some authorities say, in 90 per cent of cases of brain tumor we meet with double optic neuritis; and, third, the most frequent cause of double optic neuritis is brain-tumor. In cases of brain-tumor, we can meet with two different pictures as regards the fundus of the eye. We may find double optic neuritis in the form of choked disc, or may see the case at a later stage and find optic-nerve atrophy. In either event the picture to the ophthalmologist is a clear one, and has its distinguishing meaning. If we have an eye with a choked disc, when we look into the back part of the eye, we find the whole posterior part of the eye apparently filled up with an elevation of the optic nerve; instead of having the same plane as the retina, the nerve-head is swollen.

On account of pressure, the arteries are diminisht in size; and the veins for the same reason are enlarged and tortuous. In addition to this we frequently have hemorrhage into the nerve-fibers. This is what we mean by choked disc. There are some cases of brain-tumor, however, in which this picture is not quite so characteristic; in which the neuroretinitis is not attended by so much swelling; in which we can see vessels running from the optic nerve-head into the retina, but in which there is not a great amount of swelling. Now, as I said a moment ago, in brain-tumor we have a condition of choked disc, or we have a condition of atrophy. Now, when an oculist sees a nerve that is atrophic, it always sets him thinking; for he must then differentiate between three conditions: Physiologic excavation, an atrophy, and glaucoma. In glaucoma and in different forms of atrophy the optic nerve-head is shallow; in a physiologic excavation it is an easy matter at once to eliminate or determine the condition; because an excavation that is physiologic never extends to the periphery of the nerve-head. If the excavation extend to the periphery it is either atrophic or glaucomatous. If it is glaucomatous, we find other symptoms; for example, in glaucoma the nerve-head presents a characteristic picture; it looks as if it were puncht out, and the central vessels of the retina are seen to climb over the ledge, and it is impossible to focus the vessels climbing over the ledge and at the same time focus the vessels at the depth of the excavation. Of course, there are other symptoms that aid us in making a diagnosis of glaucoma. You probably all know that under normal conditions the arteries of the eye never pulsate; under normal conditions the ocular tension counterbalances the pressure within the vessels. So, when this relationship is disturbed, as it is in glaucoma, we find either that the pulsation is present spontaneously, or that it can be produced by very slight pressure upon the eye. There are also other symptoms of glaucoma.

Suppose we have eliminated physiologic excavation and glaucomatus excavation; we have left; atrophy. The question then arises—Is this atrophy a simple atrophy, or is it consecutive to an inflammation? and this question is an important one in making a diagnosis. For we find a simple atrophy is present in two classes of cases; we find it present very frequently in spinal diseases, for example, tubes; we find it present in some cerebral conditions, like progressive paralysis of the insane and multiple sclerosis of the brain. The question then is—Is this atrophy a simple atrophy or is it an atrophy sequent to inflammation?

In simple atrophy we find that the size of the vessels is not diminisht; we may see the line of demarcation between retina and nerve head; the nerve-head frequently looks grayish or bluish, particularly as I have seen in cases of tabes. The optic nerve-head—that is, the periphery of it—the outlines between the retina and nerve-head are regular, and that is about the picture we get in simple atrophy. Now, in the atrophy which has followed an inflammation— and that means, of course, the pouring out of an exudate—we have a different picture. Here we find the nerve head shallow, the excavation extending to the periphery; sometimes seen with difficulty. We find frequently that the vessels are paralleled and overlaid, by an exudation; we may see a whitish deposit, which is the result of an exudation. We find sometimes, as in old cases of meningitis, that the optic nerve has a very bluish appearance, and that the nerve-head instead of retaining its contour is irregular and shrunken. As a rule, the oculist has no difficulty in determining whether the atrophy of the optic nerve is simple or consecutive to inflammation.

Now, suppose we have a case in which there is double optic neuritis, what are we to conclude? We are not justified in concluding, from the presence of double optic neuritis, that the patient has brain-tumor; by no means. For we find there are many causes of double optic neuritis besides tumor; altho the most frequent cause of double optic neuritis is brain-tumor.

At this point, too, it is well to remember that there are cases of brain-tumor recorded in which there were never any symptoms, and the tumor was found only on post-mortem examination. That can happen in a brain-tumor which grows slowly without increase of intracranial pressure and without irritation at the site of the lesion. A brain-tumor does not necessarily produce double optic neuritis, for two reasons. In the first place, a brain-tumor may occur in such part of the brain as not to interfere with the optic tract; and, secondly, we find that people sometimes come to us after the optic neuritis has subsided. The double optic neuriits of brain tumor is rarely equally developt in the two eyes at the same time. If a case of double optic neuritis comes to us, we will think of several conditions; in the first place, we always think of syphilis, for that is a frequent cause of that condition; we think also of meningitis, which can produce double optic neuritis, altho not very frequently; we think of brain-tumor, which is the most frequent cause of double optic neuritis; we think of all those constitutional diseases to which the general name of anemia is given—all the way from simple anemia to leukocythemia.

Sometimes we see a case of unilateral optic neuritis—choked disc on one side. And this may be due to causes which reside in the orbit; it may be due to intracranial causes; and I believe it was Hughlings Jackson who said he believed that in these cases of one-sided optic neuritis, the tumor was generally found on the opposite side. But really the number of observations concerning that condition is very small and we should not consider that particular conclusion very valuable. Suppose we have found double optic neuritis and have excluded anemia and meningitis and syphilis; as the statesman said: "Where are we at?" Double optic neuritis is of absolutely no value in localizing a tumor. Of course, Bramwell says that tumors growing from the medulla are more rarely accompanied by double optic neuritis than tumors growing elsewhere; and I believe that Starr, in the "American Text-book of Nervous Diseases," tells us that tumors growing in the cerebellum and tumors of the corpora quadrigemina and basal ganglia are more frequently accompanied by double optic neuritis than tumors of the cortex and centrum ovale. So, valuable as is double optic neuritis as a diagnostic sign of brain-tumor, it is of no value as a localizing symptom. Double optic neuritis in the form of choked disc may come on at any time in the history of a case of brain-tumor, but it is usually an early symptom. It may appear very late. Thus Drummond has recorded a case of tumor of the medulla, lasting for nearly a year, in which choked disc appeared only ten days before death.

CLINICAL NOTES ON IODOFORM, HYDROGEN PEROXIDE, ETC.

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After reading the valuable article in the September Journal entitled, "Is Iodoform a Sine Qua Non in Gynecology," I wish to add a few words in favor of this valuable drug. I have repeatedly banisht it from my office and declared that I would no longer have the foul-smelling stuff about me, only to find cases where I would be obliged to again resort to it, as nothing seemed to take its place.

I have now found a way that partially avoids the odor. It is impossible to use the drug dry, as more or less of it will float off in the air and settle on the doctor's and the patient's clothing as well as everything else about the office. I know of surgeons upon whom the odor is constantly so pronounced that people upon the street notice it, and make remarks that are anything but complimentary. My method of overcoming this is this: The druggist prepares the following: Iodoform 2 drachms; europhen 1 drachm oil petroleum 2 ounces. Mix and put in wide-mouth, glass stopper bottle. The odor is not disguised at all, but being a thick, viscid, oily mixture, if properly handled, it need not come in contact with anything except the place where it is wisht to apply it by means of a little cotton; and possibly an instrument or two.

Some might object to the oil, but I have never seen a place where iodoform was indicated that would be injuriously affected by the small amount of oil used. I have used the europhen alone with good results, but believe the combination superior to either singly. The solution mentioned, being so thick, will adhere nicely to almost any surface upon which it is applied. When used in closed cavities, as the vagina or rectum, there need be no odor about the patient after leaving the office.

To use it one must proceed as follows: Take the bottle from its shelf and shake it until the ingredients are well mixt; then set it upon a glass or marble surface; remove the stopper and set it on a piece of paper, upon which bits of cotton used as applications may be laid, and later the whole may be rolled up and burned; have one or more wire cotton-holders handy, upon which cotton is wrapt to be dipt into the mixture, and applied to the desired spot. When the application has been completed, should any odor be detected upon the fingers or the glass upon which the bottle and instrument were laying, it may be removed by the use of alcohol or bay rum.

In this connection, I wish to report what I have found to be an exceedingly satisfactory method of treating gonorrhea in the female. Place the patient on the chair or table with hips well elevated and a rubber pad under her; irrigate the vagina with hot water and hydrogen peroxide, until perfectly clean; then introduce as large a glass cylindrical speculum as can be past into the vagina without too much pain. Elevate the external end of the speculum and pour in a small amount of silver nitrate solution, 20 grains to the ounce; drawing the speculum nearly, but not quite out, the solution will touch every part of the mucous membrane and also find its way into the cervical canal, but will not pass the internal os into the uterine cavity; now push the speculum back in as far as it will go, and remove all surplus solution with pledgets of absorbent cotton, and drop in about a half dram of the iodoform mixture, mentioned above. As the speculum is withdrawn the solution will apply itself to every bit of the cervical and vaginal mucous membrane, and unless too much has been used, none will appear on the outside. This should be repeated every second or third day for two or three times, and a cure may be expected with more certainty than by any other method with which I am familiar, provided, of course, the disease is limited to the vagina and cervix, as is the case with the majority of our patents.

I wish to enter a protest against the use of hydrogen peroxide in abscess cavities with small external openings for the egress of the contents of the abscess, especially those occurring in the ischio rectal region. As is well known, peroxide of hydrogen when brought in contact with pus, produces markt effervesence with great dilatation of any cavity in which it may be confined, unless a free outlet is afforded by which it may escape. In case it cannot escape readily, pus is forced into the surrounding tissues, where it cannot be easily reacht, and an extention into previously healthy tissue is the result. Many times this is directly responsible for the formation of extensive and troublesome fistulae. This is especially true in the ischio rectal region, owing to the great amount of loose connective tissue, and the large coarse grained glutei muscles of the buttocks. I have known of pus being aspirated from an abscess, and then the cavity forced full of a solution of hydrogen peroxide thru the aspirator needle. This is certainly poor surgery.

Hydrogen dioxide is a valuable drug, if properly used, and my only excuse for discussing it is that it may never be used in pus cases, except where there is plenty of room for it to make its escape externally.

The editor of International Journal of Surgery very pertinently remarks: In old ovarian lesions, it is often a fact that the patients show a decided insufficiency in the secretion of urea. It is well to subject such patients to preliminary treatment for this condition, for two reasons: The first is that if the proper treatment increases the excretion of urea the patient will have a better chance of recovering from the operation, and the second is that if the patient's urine shows no improvement, the prognosis is rendered more serious, and forewarned is forearmed.

ERRATUM SLIP.

The second line of Editorial in the October Number of this Journal was omitted by mistake. The attacht slip may be pasted over the Editorial note affected.

EDITORIAL NOTES.

All the world our field; all physicians our brothers.

In the excellent article of Dr. Lapthorn Smith, reference is made to the use of buried silk-worm gut sutures. I can but feel that a word of warning is needed in this particular, as too frequent employment of this particular suture material beneath the skin will lead to disappointment and trouble. If an operation be perfectly aseptic, there will be no immediate disturbance from the stitches, but in many instances there will be irritation a year or two after their insertion—in some cases sufficient to necessitate removal. In some of my herniotomies of six and eight years ago I used buried silk-worm gut sutures at the internal ring; I am still removing those stitches. I therefore say that while silk-worm gut is the ideal suture material for the skin, the cervix, etc., it must be employed with extreme caution, as a buried suture; chromicised catgut in most cases will be found better.

American Journal of Surgery and Gynecology

. . . EDITED BY . . .

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The spelling found in this magazine is that voucht for by the most prominent educators of this country; and is recommended for general adoption.

ST. LOUIS, NOVEMBER, 1899.

EDITORIAL NOTES.

All the world our field; all physicians our brothers.

A question which is now greatly discust by medical men in the State of Missouri is: Shall delegates from the St. Louis Medical Society be admitted to the State Medical Association at Mexico next spring? It will be remembered that at the last meeting of the State society a resolution was adopted declaring delegates from the St. Louis Medical Society shall not hereafter be admitted to membership until the society shall have purged itself by expelling its unethical numbers. For it has become a notorious fact that the St. Louis Medical Society has among its members some of the most disreputable of men, some of the worst newspaper advertisers, some of the most unethical doctors to be found in all America; certainly no other medical organization of any description in the world presents the spectacle of the scientific cultured gentleman sitting side by side with the most notorious quack (in heart, if not in deed); the matter finally assuming such prominence as to allow it to be no longer ignored by the great State society. So the condemnatory resolution was past.

What did the St. Louis Medical Society do? With great blowing of trumpets it expelled one lone member! And thus far the rest of the guilty ones quack on unmolested. It is true some of them have been a little less conspicuous in the public press of late; others of them have not been so openly "pushing" their 50-cent-hospital, dispensary and other schemes; the abortionists have been a little more careful in their abominable work—but the filthy ones are still retained as members. What is to be done? If the St. Louis local society contents itself with the expulsion of the one comparatively inconspicuous violator of the "Code," and does not censure or expel others, no less guilty, the State society cannot but reject the delegates who may apply for membership in 1900; and with such rejection the local society will die, since its representation in the American Medical Association will thus be killed—and the possibility of sending delegates to the State and National societies seems just now to be the chief reason for the existence of the old local society. Its scientific proceedings are very insignificant upon the whole.

On the other hand, the St. Louis Academy of Medical and Surgical Sciences continues to do good, scientific work on ethical lines. During the past year it has grown almost to its limits (50 members), its recruits being from the ranks of the younger, enthusiastic workers of St. Louis—men who are earnest and conscientious. Two men, admitted under false representations of their friends, being found to be unworthy of membership, were promptly expelled, the ambition of the members of the academy being to keep the society carefully and perpetually free from objectionable characters. Two black balls reject at the election of members. Therefore, with the safeguards of ready expulsion for unprofessional conduct, and of easy rejection of applications for membership, the State Medical Association may rest assured that none but ethical, honorable delegates will be sent as representatives of the local body. The prospects for the coming year are brighter than ever before; under the administration of the officers chosen at the annual meeting this November only the best of results are to be anticipated. The new officers are: President, Dr. James Moores Ball; first vice-president, Dr. Wm. Porter; second vice-president, Dr. H. G. Nicks; secretary, Dr. R. B. H. Gradwohl; treasurer, Dr. Emory Lanphear; orator, Dr. John C. Murphy; librarian, Dr. R. E. Wilson.

From these remarks it must not be taken that any ill-feeling exists between the two local organizations; far from it. There has thus far been only the utmost harmony between the two bodies, as a whole, with not infrequent conjoined action in good works common to both. It is only on ethical grounds that a difference arises: The St. Louis Medical, apparently without power to expel its objectionable members, or without the courage to act if it has the power; seemingly in awe of the "greatness" of some of its worst violators of the code of ethics and of the laws of common decency—certainly powerless to act in the face of the large number of votes some of these men can control; the Academy representing the better, ethical element of the local profession, standing always for professional honor, decency and purity—expelling any man found guilty of any markt violation of the rules which govern the conduct of gentlemen. The contrast is strong. The State Medical Society and the American Medical Association will surely note the difference. Let the St. Louis Medical Society clean its list of members or cease to exist.

Just now a great effort is being made by a number of Western States to oppose osteopathy, to check its spread, to secure judicial and legislative condemnation of its practice. To all the misguided, too active opponents of this fad should be given the advice: "Don't." The more it is talkt against, the more it will grow; the more it is opposed, the more it will be advertised. The best way to kill it is to leave it alone. Osteopathy is based simply upon the principle of auto-suggestion; something is being done to relieve a specified thing, and as a result of the all-powerful influence of the mind over the body a cure is often effected, especially in chronic cases. But the people will soon learn that "osteopathy" does not cure typhoid fever, small-pox, measles, diphtheria, etc.; and learning this, will promptly reject the whole practice if it be left alone. The "system" of osteopathy will die of its own weakness. The way to annihilate it is to make rational application of its good principle and ignore the "school" as a whole.

SURGICAL NOTES.

A simple and efficient means for the control of epistaxis is described in Journal of the American Medical Association, by Dr. Boyd Cornick, of Knickerbocker, Tex. He says Struempel's plan of plugging the nares with absorbent cotton is not always successful. In the class of cases he has encountered, tho sometimes there was a constitutional disturbance of the normal condition of the blood, or of the normal blood-pressure, there was likewise evidence of the existence of a localized solution of continuity in the nasal mucous membrane itself. In all such cases, were the lesion situated externally, so as to be easily visible and readily gotten at, what authority would lay stress on internal medication to constringe the arterioles, as an aid to checking the hemorrhage? What surgeon would propose astringent or styptic applications to the bleeding site? It is because the site of the lesion, in most cases of even persistent epistaxis, while not easily visible, is neverthless as easily subject to compression as tho on the external surface of the body; that in all the cases he has met within the last fifteen years or more, compression of the bleeding site has been as readily accomplisht and has been as promptly successful as tho it had been located on the external surface. All that he has found necessary has been to fashion with a pair of scissors a dry plug of prepared sponge, in size and length comparable with the little finger of a 12-year-old boy. This should be carefully soakt in boiled water, to free it of grit, squeezed dry to free it of unnecessary fluid, and inserted its full length, gently, along the floor of the bleeding nostril. No styptic is necessary; it would be needlessly irritant. The expansive pressure of the soft sponge against the bleeding site, increast by the coagulation of a few drops of blood in its interstices, will check the bleeding at once. It should be removed in twelve hours. Under no circumstance should one let it remain longer than twenty-four. Melted vaselin containing 5 per cent of carbolic acid applied with a medicine dropper in liberal quantities is the local treatment called for afterward.

An interesting contribution to the literature of the surgery of the peritoneum is an article in Journal of the American Medical Association, by Dr. H. D. Niles, of Salt Lake City, Utah. After a careful review of the surgical significance of certain peculiarities, he says that, relative to the local and general conditions which influence the protective and eliminative powers of the peritoneum, recent experimental investigations as well as clinical experience tend to confirm these conclusions: 1. Lessened blood pressure encourages absorption and favors phagocytosis. 2. A normal heart and healthy excretory organs are favorable factors in the elimination of pathogenic germs. 3. The smaller the quantity, the less the virulence, and the more general the distribution of the pathogenic bacteria, the more likely the peritoneum is to dispose

of them. 4.. Any locus minoris resistentiae offers inviting sites for the lodgment and multiplication of bacteria, and hence may retard or prevent absorption or may encourage exudation and the formation of adhesions. 5. The pressure of a foreign body, even if aseptic, within the peritoneal cavity, is an irritant and a certain producer of adhesions. All adhesions retard absorption. 7. Any interference with normal peristalsis may result in a most serious complication and is always detrimental to absorption and elimination of infection. 8. Phagocytosis is always more effective when a large area of peritoneal surface is brought into contact with diluted infection. Finally these conclusions support the belief that pathogenic germs may always be safely disposed of provided the surgeon does his work promptly and completely and is able to secure conditions that are favorable for these natural agencies to exercise their full protective powers. The general ideas of treatment, acoording to Dr. Niles, then are: 1. That peritonitis is always a surgical disease. 2. That the early operation should at all times be the one of choice. 3. That complete surgery promises more than incomplete surgery. 4. That preparatory and after treatment should include active and effective measures for the reduction of blood-pressure and increasing the activity of the phagocytic, absorptive and eliminative functions. 5. That the small incision, the least possible exposure and handling, complete removal of debris, avoidance of animal ligatures and sutures, perfect repair of the peritoneum, thoro flushing and no drainage, are all important factors in securing co-operation of these natural agencies.

Dr. W. V. Morgan, lately Professor of Fractures and Dislocations and of Clinical Surgery in Central College of Physicians and Surgeons, Indianapolis, says the rule that all fractures of the forearm should be drest in a position mid-way between supination and pronation has one important exception, viz.: Fracture of the radius above its middle. When the forearm is placed in such position that the thumb points upward, the radius and ulna are most widely separated, and as the functions of supination and pronation depend in some degree upon the integrity of this space it is proper in most cases to dress the fractures in the position recommended. The case is different, however, when the fracture is above the middle of the radius. Immediately upon the reception of such an injury, the supinator brevis muscle rotates the upper fragment into extreme supination, and if union occurs with the fragment in this position and the upper fragment pronated, or only half supinated, then the important function of supination will be either abridged or wholly destroyed. When the mountain refused to come to Mohammed, to insure a meeting, Mohammed wisely went to the mountain. We cannot place the upper fragment in other than extreme supination, and if we would insure the best result we must place the upper fragment in the same position. Hence, the important rule: "In fracture of the radius above its middle, place the forearm in such position that the palm of the hand will be directly upward."

It is announced from Paris that Dr. Bra has found the microbe of cancer, and that there is reason to hope that the discovery may soon lead to a certain cure of that dread disease. Dr. Bra is modest and cautious in his statements, saying that it must be months before a definite announcement would be possible. What he has succeeded in doing, however, is to isolate and cultivate a parasite from cancerous tumors and to produce therefrom cancer in animals. The parasite is fungus-like and he thinks it is certainly the specific agent of cancer. Dr. Bra has spent some four years in his researches on the origin of cancer.

In the Medical and Surgical Bulletin, October, 1899, Dr. C. C. Warren, Associate Professor of Surgery in the University of Nashville, reports a case of tuberculosis of the mammary gland with coexisting carcinoma of the same breast—a very rare occurrence. Cancer does not often affect tuberculous patients.

Dr. T. W. Huntington, of Sacramento, Cal., recently exhibited a boy before the local medical society, from whom he had removed the entire clavicle for tuberculous disease. The boy, 13 years of age, first came under the doctor's care 3 years ago, when he operated for an undescended tuberculous testis, associated with an incomplete hernia, removing the organ and closing the hernial ring. At the same time he removed the central portion of the right clavicle which was enlarged, painful, and evidently the seat of tuberculous invasion. This wound failed to heal, and about two months later he removed the distal end of the bone. The wound still remaining open,Dr. Huntington removed (a few months later) the proximal portion. After a short interval the disease recurred in the periosteum and reproduced bone, both of which were extirpated. Then the wound healed permanently. A mass of tuberculous subclavicular glands appeared at a later period, and these were extirpated. The boy is now in excellent condition. Has nearly doubled in stature and weight since treatment was undertaken. The function of the arm on the affected side is almost perfect. Seven important operations were done upon this boy in thirty months, but the measures adopted were clearly justified by the result attained.

Medical Review gives an abstract of a paper by Dr. J. E. Summers, Jr., Professor of Surgery in the Omaha Medical College, in which he reports a case of stricture of the esophagus complicating, and as a sequel of typhoid fever. This is the third case of the kind recorded. It was treated by Abbe's method. At the beginning of convalescence from an attack of typhoid fever, the patient developt symptoms of stricture of the esophagus, which could be readily diagnosed. When seen by Dr. Summers, only a filiform whalebone bougie could be past, and even fluids could with difficulty be swallowed. A median abdominal incision was made, and the stomach opened between two "guy-rope" sutures. A piece of heavy braided silk was past in a retrograde fashion thru the stricture by means of the filiform bougie. By a sawing motion the stricture was cut with the silk, graspt in the mouth with the left hand and in the stomach with the right, until a bougie, 16 F., could be drawn thru. It was again sawed until a larger bougie could be past, and the process continued till a 30 F. bougie past easily. The wound in the stomach was then closed by a double continuous Lembert suture, and the abdominal incision sewed up. On the third day after the operation dilation was begun, by means of bougies, and continued for several weeks, until the largest instrument past without difficulty.

GYNECOLOGICAL NOTES.

At the meeting of the American Association of Obstetricians and Gynecologists at Indianapolis, Dr. H. W. Longyear, of Detroit, read a paper on "An Operation for Shortening the Round Ligaments," the chief features of which have already been often described by Dr. J. H. Kellogg, of Battle Creek, Mich. Dr. Longyear strongly advocated the operation as the safest, simplest, quickest and surest method of the kind, as it is without danger of hernia or shock, or any serious result to the patient; after once seen is easy of performance by any skillful operator; can be done very rapidly (five or ten minutes to each side); the ligaments can always be found, and the method of fixing the loop of ligaments by weaving it into the aponeurosis admits of the patient rising from her bed sooner than with other operation for shortening these ligaments. Longyear anchors the loop with one buried kangaroo suture, while Kellogg uses two sutures of silkworm gut. The author's directions for locating the incision are very different from Kellogg's, and he thinks are more satisfactory in results. Kellogg does it by measurements, it being necessary to first locate the spine of the pubis and the superior spine of the ileum, which in a very fat subject is sometimes perplexing, where exactness is desired. Longyear's directions are: First find the junction of the femoral artery with Poupart's ligament, which is just below the internal ring, then begin the incision half an inch toward the pubis from this point; it should be about one inch in length, parallel to and just above Poupart's ligament. He looks upon this as the most important step in the operation, as exact work in locating the point of puncture of the tendon of the external oblique, thru which the blunt hook is used to wire the ligament, is thus made possible, and rapid work can be done; while if this incision is located wrong, much unnecessary groping for Poupart's ligament before the puncture can be made, is the result.

Dr. C. T. Bedford, of Indianapolis, Ind., (New York Lancet), says: Massage may well be employed along with other treatment of diseases of the mammary gland. I remember a case where a lady had a breast that seemed about to burst from induration and accumulation of milk. A neighbor came in and gently manipulated the breast carefully from the circumference toward the nipple and the milk soon began flowing freely without a breast pump. I think it best to keep the milk out of the breast in threatened mammary abscess, unless it is desired to dry the breast. When abscess is present, I consider it advisable to wean the child and dry up the breast, and therefore should not extract the milk.

Myomectomy, according to Dr. C. A. L. Reed, of Cincinnati (International Journal of Surgery), should be limited to young women with whom reproduction is an important factor, and in whose uteri there are no apparent remaining foci of fibroid degeneration. It should not be practist in cases of multinodular myomata, nor in women beyond the menopause, nor in cases presenting hopeless disease of the uterine appendages.

MARRIED.

Dr. Jabez North Jackson, Professor of Surgery in the University of Kansas City, was married October 12, 1899, to Miss Virlea Wayland, a charming Salisbury belle, the wedding being held at the bride's home. Dr. and Mrs. Jackson are now at home after an extended western trip.

INDIAN TERRITORY SOCIETY.

The Indian Territory Medical Society will meet at Wagoner, I. T., December 5 and 6, 1899, with the following program:

"Typho-Malarial Fever"—By Dr. W. O. Shannon, Durant, I. T.

"Pernicious Malarial Fever"—By Dr. W. A. Tolleson, Eufaula, I. T.

"Medical Treatment of Appendicitis" — By Dr. M. F. Williams, Muscogee, I. T.

"Diabetes Mellitus"—By Dr. A. M. Clinkscales, Vinita, I. T.

"The Heart in Disease"—By Dr. B. F. Fortner, Vinita, I. T.

"Merit versus Time Requirement for Graduation in Medicine"—By Dr. Leroy Long, Caddo, I. T.

"Croup"—By Dr. A. Griffith, South McAlester, I. T.

"Capillary Bronchitis in Children" — By Dr. J. D. Brazeel, Wagoner, I. T.

"Fevers in Children"—By Dr. J. D. McLaren, Muscogee, I. T.

"Pneumonia in Infants" — By Dr. E. Pleas, Oolagah, I. T.

"Fractures of the Skull"—By Dr. I. P. Lumby, Sherman, Texas.

"Fractures of the Upper Extremity" — By Dr. F. B. Fite, Muscogee, I. T.

"Fractures of the Lower Extremity"—By Dr. J. S. Fulton, Atoka, I. T.

"Fractures of the Spine and Trunk"—By Dr. R. I. Bond, Hartshorne, I. T.

"A Country Doctor's Treatment of a Fractured Femur"—By Dr. F. S. Chilton, Tusla, I. T.

"Injuries of the Head"—By Dr. St. Cloud Cooper, Ft. Smith, Ark.

"Medical Jurisprudence from a Surgeon's Standpoint"—By Dr. G. R. Rucker, Checotah, I. T.

"The Importance of Movable Kidney in its Relation to Ill Health"—By Dr. Emory Lanphear, St. Louis, Mo.

"Difficult Labor"—By Dr. David Gardner, Lehigh, I. T.

"Puerperal Eclampsia"—By G. W. West, Eufaula, I. T.

"Abortion"—By Dr. V. Berry, Wewoka, I. T.

"Salpingitis" — By Dr. T. S. Chapman, South McAlester, I. T.

"Management of Uterine Retropositions" —By Dr. M. B. Ward, Kansas City, Mo.

"Naso-Pharyngeal Adenoids"—By Dr. H. Moulton, Fort Smith, Ark.

"Indications and Operations on the Eye Muscles"—By Dr. L. Haynes Buxton, Guthrie, Ok.

"Pannus and Vascular Keratitis"—By Dr. F. B. Tiffany, Kansas City, Mo.

THREE STAGES IN THE DEVELOPMENT OF GENITAL DISEASE. * * *

VAGINITIS

often represents the first stage in a series of morbid processes, which, if neglected or improperly treated, may have serious and far-reaching consequences. The fact that it is usually of gonorrheal nature explains the tendency of the inflammation to invade the uterus and adnexa. Hence the importance of early treatment by an efficient yet unirritating antiseptic and astringent application. Timely resort to such a preparation as Micajah's Medicated Uterine Wafers will prevent the upward extension of the infection from the vagina to the uterus and the development of

ENDOMETRITIS

which is the second stage in the history of these cases. To eradicate the infection from the uterus and prevent serious changes in the mucous membrane it is necessary to resort to measures which will relieve congestion, destroy the infectious element and exert an alterative effect. For this purpose Micajah's Medicated Uterine Wafers and highly recommended and have proven an important adjunct in the treatment. If, however, the disease is not vigorously combated it may extend along the tubes, producing

SALPINGITIS

or may affect the ovaries and pelvic peritoneum. While in some of these cases surgical intervention is demanded, in many others local medication is of great benefit, and will obviate the necessity of operative measures. Much may be accomplished by the use of Micajah's Medicated Uterine Wafers in diminishing pelvic congestion and in exerting an alterative and tonic effect upon the genital tract.

THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

The following officers were elected for the coming year:

President—Dr. Harold N. Moyer, Chicago, Ill.

First Vice-President—Dr. A. H. Cordier, Kansas City, Mo.

Second Vice-President—Dr. S. P. Collins, Hot Springs, Ark.

Secretary—Dr. Henry E. Tuley, Louisville, Ky.

Treasurer—Dr. Dudley S. Reynolds, Louisville, Ky.

Ch. of Com. of Arr.——Dr. M. H. Fletcher, Asheville, N. C.

Twenty-sixth annual meeting will be held at Asheville, N. C., October 9, 10 and 11, 1900.

A CASE OF LUPUS.

E. H——, New York; American; age 43; first seen April 1, 1898. Lupus on the back of left hand, of the size of a silver dollar. The case had been treated four years, during which time he says twenty-five physicians had a chance at it, but it had never healed, altho it had not spread rapidly. The patient is a man of considerable intelligence and of an inquiring turn of mind, and therefore I was able to find out from him just what the variety of treatments had been; consisting of about everything known in practice except blood treatment, even to the actual cautery and curettement. I advised immediate curettement, to which he consented, and it was done, under topical cocaine anesthesia, and done very thoroly. Following this, the surface was touched up with a 25 per cent. solution of pyrozone, and bovinine was injected all around the circumference of the ulcer, just beyond the line of demarcation between the healthy and unhealthy tissues. It was then drest with a wet Thiersch pack. At the end of twenty hours the dressing was removed, and the bovinine peroxide depuration with Thiersch irrigation was performed. Iodoform-bovinine dressing was applied and renewed daily until April 15, when another thoro depuration with peroxide on bovinine was given, with Thiersch irrigation, and dressing now with bovinine pure. The process of healing to this time had been slow, but the surface of the ulcer had been gotten into a healthy condition. Thenceforward the progress was satisfactory, and by April 27 the ulcer had healed over full two-thirds of its extent, and the outlying tissues surrounding it were in a healthy condition, without the slightest indication of any secondary tubercular deposit. From this time on the ulcer was dressed twice a day. May 20 the patient was discharged cured, the wound having entirely and absolutely healed, leaving only a pink scar, soft and sensitive, but not painful.

CARD ENCLOSED.

We want non-subscribers to sign and return the enclosed card.

FOR ENGORGED CERVIX.

Micajah's Medicated Uterine Wafers, made by Micajah & Co., Warren, Pa., are valuable in cases of engorgement of the cervix uteri, where they afford marked relief; in fact, in all inflammatory conditions they are highly beneficial and in cases of endometritis decided improvement has been reported from their use.

THE FLAG OF OUR UNION.

She scarce had been three months a wife
When I discovered her astir,
With scissors, cloth and needles, rife,
To make the banner of our life—
The diaper!

And now, while I indite these lines,
Full of poetic fire, as 'twere,
Those other lines are hung with signs
Of married bliss, among which shines—
The diaper!

On Homer's bust, beside my door,
Among my books, though I demur,
All redolent upon the floor,
I see it scattered by the score—
The diaper!

And when I drink in health and pore
On love's young dream and joys that were,
The little rascal on the floor
Pours his libations, more and more—
The diaper!

Yet should I swear—I'd strike a snag—
My little wife would raise a stir,
And flaunt aloft the dangerous rag,
And call me traitor to the flag—
The diaper!

—Geo. M. Gould.

SOUTHERN SURGICAL.

The meeting of the Southern Surgical and Gynecological Association will be held in New Orleans, December the 5th, 6th and 7th, under the presidency of Dr. Jos. Taber Johnson, of Washington. Prospects are splendid for a successful occasion. Members of the medical profession are cordially invited to attend.

RAILWAY SURGEONS ELECT OFFICERS.

The American Academy of Railway Surgeons held an interesting meeting at Omaha, Neb., October 12 and 14. The following officers were selected for the ensuing year: President, Dr. Charles A. Wheaton, St. Paul; first vice-president, Dr. A. F. Jonas, Omaha; second vice-president, Dr. T. J. Eskridge, Denver; secretary and editor, Dr. T. B. Lacey, Council Bluffs, Iowa; treasurer, Dr. D. S. Fairchild, Clinton, Iowa. St. Paul was selected as the next place of meeting. The visiting surgeons were tendered a banquet by the Omaha members.

TO ADVERTISERS.

The attention of advertisers is directed to the following list of bona fide, new, annual subscriptions to the AMERICAN JOURNAL OF SURGERY AND GYNECOLOGY, received during the 30 days preceding the issuance of this number of the Journal. **During the past four years we have printed the names and addresses of nearly 6,000 NEW SUBSCRIBERS.**

This is something *no other medical journal in the world* has ever before been able to do!

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